STIMULATION OF ALTERNATIVE HEALTH CARE DELIVERY SYSTEM DEVELOPMENT

Final Report

Grant Number 18-P-97019/5

InterStudy

Prepared for:

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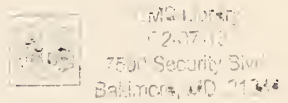

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List of Publications resulting from the Project

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Sample of a Community Data Profile: Beaumont, TX

STIMULATION OF ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS

I. EXECUTIVE SUMMARY

The project was funded by the Health Care Financing Administration under two separate grant awards for a total grant period of four years. The objectives, approach, and activities varied from the first two-year period (Phase 1) to the second two-year period (Phase 2), but the overall goal remained the same: to stimulate business support for the growth and development of Alternative Delivery Systems (ADSs)* throughout the country. In particular, the project team proposed to work directly with major U.S. corporations to promote the development of business-initiated and business-sponsored ADSs. In order to accomplish this, project staff developed and implemented a series of steps designed to activate corporate interest; educate corporations on the nature of the health care cost problem and the potential cost savings of ADSs; assist in formulating a corporate position; and finally, implement corporate action steps supportive of ADSs.

A. Summary of Project Objectives

Phase 1 Objectives (Years I and II)

The objectives for Phase I included such start-up activities as information gathering, general climate building, and the development of criteria for selecting the target companies. By the end of the second year, the project team planned to have selected and worked directly with 15 U.S. corporations. In addition to the overall goal of stimulating support for ADSs, the staff agreed to document the outcomes and methodology employed. The four major objectives for Phase I were:

1. Establish an ADS/Business Information Center which identifies and reports on ADS activities taking place. Use the Information Center to track progress in corporate sponsorship of ADSs, to serve as a basis for selecting target businesses, and to assist the Office of HMOs (DHHS) in its data gathering and promotional efforts.

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*The most prominent form of ADS is a Health Maintenance Organization (HMO) which is offered by employees as an alternative to the company's traditional health insurance.

2. Identify six (6) corporations or coalitions of corporations and community interests in Year I and nine (9) in Year II that are most likely to be instrumental in supporting ADS formation and growth, based on key characteristics and health care situation.

3. Undertake studies in target companies to carry them to the stage of a corporate decision to actively support and/or sponsor ADS formation and growth.

4. Document the methodology employed in the decisionmaking processes of target businesses in a manner that will allow other businesses to make appropriate policy decisions on ADS support/sponsorship.

Phase 2 Objectives (Years III and IV)

The original goal of the project remained the same, but the objectives and activities for Phase 2 were modified to focus on a smaller number of companies with a more specific agenda. In addition to the general support for ADSs which the project team hoped to foster by working on internal cost containment issues and initiating employer coalitions (Objectives 1 and 2), the staff also hoped to stimulate interest in direct ADS sponsorship as a new venture for the corporation and the development of innovative retiree demonstrations whereby new approaches to financing and delivering health care to Medicare-eligible retirees could be tested (Objective 3). Because of the very specific nature of Objective 3, very large companies were selected which either had the financial resources and related technical expertise to consider HMO formation as a new venture, or a sizable number of retirees for whom they offered supplemental health benefits. In summary form, the major objectives for Phase 2 were as follows:

1. Collaborate with five leading companies to select a major target community (and one to two secondary targets, if they choose).

2. Support the actions of five lead companies to catalyze change in the health care delivery system of one community in which it is a dominant employer.

    a. Help each lead company organize and carry out a local employer coalition to investigate the local health care delivery system and determine whether business support of ADSs is appropriate and desirable.

b. Provide staffing for employer coalition activities.

c. Explore with and recommend to each company ways in which it can increase the cost effectiveness of the health care dollars spent for both employees and retirees.

3. Examine with lead companies the desirability and practicality of direct ADS sponsorship and of innovative retiree demonstration contracts.

   a. Explore with each company the desirability and practicality of developing a company-sponsored ADS for the dual purposes of stimulating competition in the community and creating a laboratory for applied research that will help the company develop and test new products and systems.

   b. Investigate the issues, for the companies and for HCFA, associated with various methods of offering retirees the option of HMO enrollment or other capitation arrangements on a demonstration basis.

B. Project Approach

Phase 1 Approach (Years I and II)

The project team recognized that there were two stages to successful implementation of the project: first to stimulate the interest and commitment of target companies likely to adopt a pro-ADS stance, and second, to work within each of those companies once an agreement to participate was reached. The InterStudy team worked closely with the Office of HMOs (HHS) to coordinate promotional/educational activities and initiated the following climate building and marketing techniques designed to stimulate interest:

- publishing articles and reports and promoting media coverage;
- participating in business conferences;
- speaking to appropriate business and health provider audiences; and
- coordinating with OHMO as well as the National Chamber Foundation, the Washington Business Group on Health, NAEHMO, etc.

The approach included the establishment of a business/ADS information center that would monitor ADS development, business involvement in ADSs, and available consultants. From the information gathered, and through the various marketing

and promotional activities, the project staff selected 15 target corporations or coalitions of corporations based on criteria designed to identify companies which may be more likely to sponsor the development of ADSs: high labor intensity, excessive health care costs, geographical concentration of employees, adequate supply of management expertise, support by labor unions, support of key corporation leaders, etc.

Once the companies were selected, the project team conducted an analysis of the corporations' health care programs, focusing on characteristics that would facilitate the process of ADS development. A final product of the project was a general discussion of the corporate decision process and observations on the factors favorable to a positive decision regarding ADSs. Two other methodologies developed included a "Design for a Corporate Health Care Monitoring System" and a "Design for a Community Health Care Study Process". These products are available to help other corporations considering ADS development.

The final step was to assist those corporations in activities supportive of ADS growth and development. For those companies deciding to investigate actual sponsorship, the project team assisted in the conduct of a feasibility study for ADS development, including coordinating the necessary technical assistance and consulting support.

Phase 2 Approach (Years III and IV)

Because the project team had an earlier association with four of the five corporations selected for Phase 2, less preliminary work was required. Formal day-long planning meetings were held with the five corporations early in the project year. Each meeting included a review of the three objectives outlined above, an overview of the company's health care cost containment strategies and policies, and HMO experience and policies. Also at this time, company representatives started the process of determining specific activities to be carried out for each objective (i.e., selecting a target community, methods of working with coalitions, cost containment initiatives, etc). Objective 3 was discussed at this meeting, but further activities were postponed until work was underway on the first two objectives.

Following the initial planning meetings, InterStudy staff was in close contact with each company to finalize the activities each would be involved in. Many activities were company-specific, but other activities were conducted as joint projects -- a seminar for health care coalitions, a conference on corporate data monitoring, and retiree demonstration feasibility planning. In all cases, a program was developed for the two years tailored to each company's concerns and addressing the three objectives above. A major portion of Year III was spent working with the companies in their selected Target Cities and with local coalitions. This work was continued in Year IV. Also in Year IV, a number of background papers were developed for companies regarding the desirability of a retiree demonstration and sponsoring an ADS. These papers were used as a basis for discussion with the companies as they considered further steps they might undertake.

C. Project Outcomes

The final report details the progress toward achievement of each specific project objective. For the purposes of this executive summary, however, we will provide a brief overview of the outcomes for each two-year Phase. In general, the project team regards Phase 1 as the more successful of the two; that is, there is more tangible evidence of corporate support for ADS growth and development directly attributable to Phase 1 activities.*

Phase 1 Outcomes (Years I and II)

1. Climate-building -- Considerable effort was devoted to activating employer interest in cost containment in general and coalition building and support for ADSs in particular. The rapid proliferation of employer health care coalitions over the last four years, in large part, can be attributed to InterStudy's work on this project and our publication of "A National Health Care Strategy", in 1978 through the National Chamber Foundation. InterStudy's early work with several prototype coalitions (Des Moines, Dayton, Ft. Wayne, Akron, Minnesota, and Utah) continues to provide direction for other employers and coalitions.

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*Section D, which follows, presents our conclusions and analysis.

2. ADSs Directly Attributable to this Project --

   a. Dayton, OH -- strong support from a high level employer employer coalition led to the successful introduction of two HMOs.

   b. Stamford, CT -- work with a local CEO and through him, an industry council, were important factors in the implementation of a group model HMO.

   c. Preoperational ADSs in: Birmingham, Des Moines, and Akron. Project staff assisted coalitions in each of these communities -- established conditions that have influenced new ADSs to begin development efforts.

3. ADSs Indirectly Attributable to this Project --

   a. Quad Cities -- ongoing support for Deere-sponsored HMO; operational 1980.

   b. Champagne/Urbana -- assistance to multispecialty group practice; HMO operational 1979.

   c. Preoperational ADSs in: Rockford, Oklahoma City, Ft. Wayne. Promotion and assistance to employers and providers that has culminated in HMO start-up efforts.

4. Companies Adopting a Positive ADS Policy -- The project team was successful in persuading three individual companies and four coalitions of employers to adopt pro-ADS and pro-competition policies.

   The coalition efforts occurred in communities where there was no, or very limited, HMO activity but where planning or development of an HMO was underway. In each case, CEOs and top level executives of the local companies realized they needed to develop a formal posture on HMOs for their community, and decided to study the issues through a joint employer coalition. The project team provided interim staff support, speakers, and site visits for the coalitions in Akron, Dayton, Des Moines, and Ft. Wayne. At the conclusion of the study, the coalitions endorsed HMOs as a positive alternative to health care financing and delivery. In Des Moines and Dayton, the coalitions have continued to play an active, shaping role in ADS development with strong CEO level involvement. In Akron and Ft. Wayne, the coalitions disbanded but representatives of individual companies became active supporters of HMOs that are now operational.

   The three companies which adopted pro-ADS stances included Companies A, E, and J. The project staff conducted a health benefits audit for A and J and provided direct assistance in developing a corporate policy statement on health care cost containment and ADSs. Dr. Ellwood, through contact with the CEO and benefits manager of Company E, was instrumental in the adoption of an active program of support for HMOs, including the development of very positive HMO offering materials, in kind staff support to an HMO in Company E's headquarters city and putting HMOs on the agenda of the local industry council. This company's very active stance has attracted national attention and has proved to be a potent model for other companies.

Phase 2 Outcomes (Years III and IV)

1. Action in Communities (One community for each of 5 companies)

   a. New Coalitions -- two of the companies initiated coalitions, one in Beaumont, Texas, the other in Endicott, New York. Staff was not successful in directing their efforts toward ADS formation, however.

   b. Ongoing coalition -- project staff continued its support of the Dayton HMO Task Force which has significantly aided the growth of two new HMOs.

   c. Independent corporate action -- in two cases the corporations decided to act on their own. In Gary the project team helped one company revise HMO offering materials and procedures on a pilot basis: enrollment increased by 28%. In Philadelphia, staff assisted one company in planning the development of a Preferred Provider Organization (PPO). Efforts continue as of the time of this report.

2. Internal Cost Containment and Corporate HMO Policies

   The impact of much of the work conducted in this area is difficult to measure (e.g., seminar on corporate monitoring, special analyses of one corporation's cost and utilization data, assessment of one company's cost management program, etc.). We believe these activities to be important steps, however, in educating and motivating companies to take action.

3. Retiree Demonstrations

   Two of the companies decided not to pursue this option in any detail. Of the three corporations that did work extensively with project staff, one decided to drop consideration because the company did not wish to pursue an HMO demonstration and decided an insurance experiment would place the company at too great a financial risk. Two companies are continuing their exploration; one shows particular promise of follow up with both an HMO approach (HMO accepts a capitation from both the employer and HCFA and is at financial risk) and an insurance approach (the insurer designs a delivery approach under which it is willing to go at risk).

4. ADSs as a New Venture

   None of the five companies decided to pursue formal feasibility studies. Two of the companies were interested enough to consider it at an appropriate level in the corporation: top executives in the new ventures or strategic planning divisions. Both decided that it was not an attractive corporate strategy and closed the discussions.

D. Conclusions and Recommendations

An Overview of Corporate Attitudes Toward Health Care Cost Containment

Based on InterStudy's experience through this project, our many contacts with corporations other than the target companies, and various recent reports and articles*, we believe that U. S. corporations are only slowly evolving toward an active role in health care cost containment. This could result in a significant change in business's traditional role, but corporations remain cautious, preferring, for the most part, to confine themselves to low risk "tinkering" to achieve cost savings. A handful of corporations provide bold exceptions, but the following characterizes the attitudes of American business and industry during the course of this project:

1. Health benefits are primarily a means to attract and retain employees -- employers are reluctant to appear stingy or self-serving through aggressive cost containment efforts.

2. Business executives traditionally have been patrons of the medical community, especially hospitals. Their role in the past has been as supporters of the effort to bring the latest in technology and expertise into their communities.

3. It is not considered appropriate for business to intervene directly in the medical care system, but it is appropriate for corporations to establish a dialogue with providers, respond positively to ADSs, negotiate discounts and review appropriateness, purchase health care in a way that rewards cost effectiveness, and work on public policy changes.

4. To directly sponsor health care delivery organizations is outside their area of expertise and interest -- they are not interested in diversifying to that extent.

Furthermore, companies big enough to have real clout as purchasers are usually large bureaucracies. Attempting to attract the attention of the CEO or top level executives who can make major policy decisions is difficult. The health benefits department has to compete with numerous other departments for attention. In addition, significant changes in the delivery system require local action; companies are most willing to become involved in local systems change in their headquarters' communities.

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*Two recent articles that provide an excellent review include: Sapolsky, et al., Corporate Attitudes Toward Health Care Costs, Milbank Memorial Fund Quarterly, 1981; 59: 561-85, and Iglehart, Health Care and American Business, New England Journal of Medicine, 1982; 306; 120-124.

Rapidly rising health care costs in recent years are beginning to break down corporations' reluctance to be more active, cost-conscious purchasers. Examples of recent actions by American business are listed below from the lowest level of interest and commitment to the highest. It is important to note that many companies are trying the first four approaches; few companies are adopting the last three.

- Formation of national and local employer cost containment groups
- Redesigning benefits to discourage over-utilization of services
- New efforts to collect and analyze health cost and use data -- pinpoint problem areas, devise solutions
- Appoint a cost containment specialist within the benefits department
- Instituting concurrent private utilization review to reduce unnecessary hospital use
- Actively promoting the cost containment potential of HMOs and competition
- Becoming direct sponsors of HMOs and other alternative delivery systems.

Conclusions Regarding Project Outcomes

1. It is highly unlikely that large corporations not already involved in the insurance or health care delivery industry will find ADS development an attractive investment. It is a radically new line of business, the risk factors appear high and they see little prospect of transferring their management or systems capabilities to what is essentially a very unique type of service industry.

   Note: The few U.S. industrial firms that have sponsored HMOs (R. J. Reynolds, Deere, Ford Motor and recently, Caterpillar, and a Des Moines employer coalition) did so only in their headquarters' city or to serve a major portion of their work force.

2. It is highly unlikely that corporations will take the lead in developing insurance or HMO experiments in order to enroll their retirees in ADSs. They are, however, interested in becoming a part of an on-going demonstration; e.g., enabling their retirees to enroll in an on-going HMO Medicare demonstration, particularly if it is an HMO already offered to their active workers.

Note: Of the five target companies, the one that is actively pursuing a demonstration will offer the option (1) through a current HMO/Medicare demonstration or (2) if their insurer is willing to accept the risk on Medicare Parts A and B and the company supplement.

3. Corporations, independently or in coalitions, will take a number of important actions supportive of ADSs: establish corporate policy and offering procedures favorable to HMOs, sit on HMO boards and committees, actively encourage the formation of ADSs within local communities, and counteract negative response to ADSs from the medical community.

Note: Of the 15 target companies and coalitions in Phase 1:

-- 11 were actively supportive of HMO growth and development

-- 2 were generally supportive of the HMO approach

-- 2 remained highly skeptical

Of the 5 target companies in Phase 2:

-- 3 were actively supportive of HMO growth and development

-- 2 were generally supportive, but somewhat skeptical

Specific Recommendations Based on Our Work with Target Communities

Based on our successful efforts; i.e., companies or coalitions which decided to actively promote the growth and development of HMOs through our work on this project, we offer the following recommendations.* We suggest that any group or individual wishing to move a corporation toward active support for HMOs or direct sponsorship of an HMO is more likely to be successful if the following approach is used:

1. Selecting the Company

We found the following characteristics common among the companies and coalition leaders which progressed the furthest toward direct, active support of HMOs:

- Mid-sized national corporations (approximately 10,000-75,000 employees)
- Concentrated employee populations in mid-sized cities
- Not in a medical (drugs, equipment, etc.) industry
- CEO or top level executive willing to take the lead

*It is more difficult to draw conclusions regarding the companies with whom we experienced less success, but it is of interest to note that, for the most part, both the characteristics of those companies and the process we were able to use were opposites of the "success stories".

2. Process of Working with a Company

A substantial educational effort is required before employers are confident enough to challenge the medical community. The following steps were most effective in stimulating corporate interest and action:

- Activate the interest and commitment of the CEO or top level executive.

- Focus on the headquarter's community first, include several other prominent employers and labor, if appropriate.

- If a coalition of employers is used:

  a. focus the group initially on the single objectives of studying the appropriateness of HMOs;

  b. do not include physicians and hospitals except as visitors and in small numbers; and

  c. keep the study period short (3-4 months) and then develop action plans

- Present evidence that competition in health care is an appropriate long-range strategy for cost containment (speakers, printed materials, site visits of competitive markets, etc.).

- Provide analysis and support as the group considers how it might spur ADS development in the headquarter's city.

- Be sure that one person with the time and interest is assigned to implement the company's strategy (may be the CEO, more likely the VP of Personnel).

II. FINAL REPORT FOR PHASE 1 (Years I and II)

A. Statement of Objectives and Approach

The original purpose of the project as stated in the proposal was to promote the development of business-sponsored and business-initiated Alternative Delivery Systems (such as HMOs, HCAs, etc.) throughout the country. The project staff indicated that very little empirical evidence existed as to "what motivates corporations to develop an ADS or, for that matter, which corporations are likely to contain elements interested in such activities." In spite of the fact that few corporations had actually sponsored ADSs, the project team believed that if they could be persuaded to, "enough is known about the ADS development process that it could be oriented toward corporations and labor and systemized to some extent." It was further believed that if corporate and labor support could be generated, it would galvanize the interest of others in developing ADSs.

In the continuation application for Year II, the project team requested and received approval for broadening the goal to include adoption of a corporate position of active support for ADS growth and development, recognizing that in-house development of an ADS was an unrealistic goal in the time allotted. The few companies that had sponsored HMOs required up to seven years lead time prior to actual implementation.

The major objectives for Phase 1 of the project, as revised in Year II, were as follows:

1. Establish an ADS/Business Information Center which identifies and reports on ADS activities taking place. Use the Information Center to track progress in corporate sponsorship of ADSs, to serve as a basis for selecting target businesses, and to assist the Office of HMOs (DHHS) in its data gathering and promotional efforts.

2. Identify six (6) corporations or groups of corporations and community interests in Year I and nine (9) in Year II that are most likely to be instrumental in supporting ADS formation and growth, based on key characteristics and health care situation (i.e., excessive costs, corporate interest, labor intensity, geographical concentrations, etc.).

3. Undertake studies in target companies to carry them to the stage of a corporate decision to actively support and/or sponsor ADS formation and growth.

4. Document the methodology employed in the decisionmaking processes of target businesses in a manner that will allow other businesses to make appropriate policy decisions on ADS support/sponsorship.

Overall Approach

The project team recognized that there were two stages to successful implementation of the project: first to stimulate the interest and commitment of target companies likely to adopt a pro-ADS stance and second, to work within each of those companies once an agreement to participate was reached. The InterStudy team worked closely with OHMO staff to coordinate promotional/educational activities and initiated the following climate building and marketing techniques designed to stimulate interest:

- publishing articles and reports and promoting media coverage;
- participating in business conferences;
- speaking to appropriate business and health provider audiences; and
- coordinating with OHMO as well as the National Chamber Foundation, the Washington Business Group on Health, NAEHMO, etc.

The approach included the establishment of a business/ADS information center that would monitor ADS development, business involvement in ADSs, and available consultants. From the information gathered, and in the various marketing and promotional activities, the project staff selected 15 target companies based on criteria designed to identify companies which may be more likely to sponsor the development of ADSs: high labor intensity, excessive health care costs, geographical concentration of employees, adequate supply of management expertise, support by labor unions, support of key corporation leaders, etc.

Once the companies were selected, the project team conducted an analysis of each corporation's health care programs, focusing on characteristics that would facilitate the process of ADS development. A final product of the project was a general discussion of the corporate decision process and

observations on the factors favorable to a positive decision regarding ADSs. Two other methodologies developed included a "Design for a Corporate Health Care Monitoring System" and a "Design for a Community Health Care Study Process". These products are available to help other corporations considering ADS development.

The final step was to assist those corporations in activities supportive of ADS growth and development. For those companies deciding to investigate actual sponsorship, the project team was prepared to assist in the conduct of a feasibility study for ADS development, including coordinating the necessary technical assistance and consulting support.

The section which follows summarizes the activities and evaluates outcomes for each of the fifteen target companies. Each company is described by an alphabetical code in order to facilitate a candid discussion of factors within the company that were favorable or unfavorable.

Company A

Description of the Company:

This medium-large Fortune 500 manufacturer of heavy equipment operates on a very decentralized basis, in part because of the number of subsidiary relations and because of its diverse products. It is fairly heavily unionized and has multiple contracts. Headquartered in the Midwest, the company has 20 divisions and 80 locations throughout the country.

Because of the heavy acquisition of subsidiaries, Company A currently deals with four separate insurers for various parts of the company's business. The company has offered the HMO option for several years, but has significant penetration only in its West Coast locations. A major subdivision of the company has instituted a flexible benefits program which directly rewards employees for choosing HMO options when those options are less costly than the company's program. It is known that the CEO has an interest in and some knowledge of health care; however, apart from the initial expression of interest, he has not been actively involved in the company's deliberations and subsequent activities.

Summary of Activities:

The company's interest in investigating various policy options enabled the project team to be of considerable assistance in reviewing a prior consultant's report and in helping the company deal with its insurance carriers. The project team also was able to explain the benefits of a cohesive company statement on health care and health care costs which would embrace corporate contributions, health education and promotion activities, health benefits, plan design, and support for alternative delivery systems. This approach proved attractive to Company A, and a corporate policy was subsequently implemented and adopted.

At the company's request, the project team reviewed community health care systems in ten selected communities to provide a preliminary idea of the appropriateness of conducting an ADS feasibility study in those locations. While this report indicated some potential for corporate activity, it was determined that such

activity should be carried out at the local level. Company A's subsequent efforts to interest local plant personnel in community coalition activities were not very successful. This experience led to a rethinking of Company A's stance and the realization that only if operating managers were responsible for the management of their health care costs and if they perceived that they could influence the health care costs (and, potentially, the health) of their employees would they take an active interest in supporting alternative delivery systems in their communities. With this in mind, the project team and company constructed a prototypical employer's health care cost and utilization tracking system.

Company A took the prototypical employer health care information system format in late 1979 and worked during the winter of 1980 to further refine this system with its insurers and data processing personnel. System implementation was approved by management; however, due to a very large backlog in converting the existing system to a new data processing system, the timetable for system implementation was pushed back to early 1981.

Analysis:

The project team regards its efforts with Company A as quite successful. Our educational and data gathering efforts were successfully translated into adoption and implementation of a corporate health care policy which includes a positive stance on alternative delivery systems. The timeframe for these activities was longer than the project team had anticipated and once again points out the problems of working with large companies, and to the requirement for any such policy to go through multiple corporate layers.

The presence of multiple insurers and multiple unions made the company's health care benefits situation very difficult to analyze and understand; however, the process of working with those insurers on the health care information system appeared to contribute to more cooperative working relationships which will benefit the company in the long run. The project team's efforts to interest local personnel in taking an active stance on ADSs in a specific community were not very successful in the short run. However, it was hoped that when

data from the health care monitoring system were routed to division and location managers and those managers were held accountable for their costs, interest in delivery system change and ADS stimulation would increase sharply and remain high since the company would then have documented evidence to back up its positions and concerns.

Critical Factors:

Positive:
1) The president reaffirmed his interest in coordinating company policy and specific actions, and was looking for action.
2) A specific person was assigned to produce reporting requirements report and follow up.

Negative:
1) The employee benefits manager, charged with overall responsibility, may be more interested in external activities than progress on internal company policies and actions.

Company B

Description of the Company:

Company B is a vertically integrated company that extracts and processes basic substances. Of its 50,000 plus employees, approximately 30,000 are located in the United States, and of those there are major concentrations at three locations, one in the Great Lakes region, one in the south, and one in the southwest. The company is basically non-union and has a keen interest in remaining so. Company B has a decentralized organizational structure in which regional managers oversee multiple operating units. The company promotes and transfers persons on a frequent basis; thus, there is a constant influx of new people into the major locations, and fairly widespread knowledge about conditions and benefits at other locations.

HMOs have been offered in a limited scale in Company B, primarily on the West Coast. The company's experiences with its HMO offerings have been largely favorable. The two reasons for formation of an in-house Health Care Cost Containment Committee were sharp price increases for employee health care over the past three years and an expression of interest by top management. Concurrent with the activities of the committee, this self-insured and self-administered company was implementing a computer-based health care utilization and cost tracking system based on claims data.

Summary of Activities:

Company B was the first with which the project team was able to establish a working relationship. Company B learned of InterStudy through employee benefit sources and approached the project team in the fall of 1978. The initial approach was made by the person on special assignment to staff the company's health care cost containment committee. This person sought outside expertise to advise the committee in its deliberations and help it to reach suitable and effective recommendations. The president and the CEO had directed that such a committee be formed in July of 1978.

InterStudy's goal in working with Company B was to persuade the company to take an active stance towards ADS support and sponsorship in its three major employment concentrations. The project team conducted preliminary investigations into the health care delivery systems of the three major locations and used the results of those evaluations to undertake educational efforts with the company's internal health care task force, which included major operational personnel. Project staff presented eight recommendations, which Company B could implement in order to exercise influence on local health care delivery systems, offer HMO options in a positive framework to employees, and work to make HMO options available to employees in each of its major locations.

In early 1979, project staff assisted Company B's committee to explore the local health care situation with local providers. Staff also aided in drafting a letter to Company B managers expressing the committee's concern regarding health care costs. This letter was later adapted for distribution to Company B employees.

Analysis:

The project team was able to establish its credibility at early meetings with the committee by virtue of the ability to explain the reasons for Company B's health care cost rises, and by our knowledge of the health care systems in communities where Company B had major employment locations. The project team was able to establish good rapport with the committee staff person, the employee benefits manager, and at least two other members of the committee. The project team feels that its work with Company B was appropriate in the short-run, in that we were able to create an educated and motivated group of persons within the company who had a mandate to make recommendations on corporate policy and who were themselves fairly influential. While "doing something about health care" was seen as a personal interest of the chief executive officer, other senior personnel proved to be against any stance that might have a negative effect on area hospitals with which the company had been associated. Occupational health considerations also made this company wary of adopting an active stance. Influenced by these considerations, the company decided to postpone any immediate or direct local action and form committees at each of the three major locations to investigate options for local health care cost containment.

While this outcome was considerably weaker than that for which the project team had aimed and almost certainly precluded any action in the headquarters area, it did allow those whose interest had been aroused in a southwestern location to pursue investigations.

Possibly the major significance of the project team's work with Company B was its substantial educational value for the project team. The blocking of the committee's work just as it was about to reach fruition was frustrating, but served as a valuable object lesson on the necessity to ascertain the attitudes of all top management personnel who have more influence with the president than does any committee member, especially if the committee report must go through those persons to reach the president.

Critical Factors:

Positive: 1) The task force's decision to leave action to the discretion of local managers created an opportunity, though not necessity, for pro-ADS actions.

Negative: 1) The failure to adopt a corporate-wide stance removes any requirement for significant action.

2) The powerful V.P. who does not want the company involved in any ADS activities is closer to the CEO than are those who want to see the pro-ADS stance. Reassignment of two persons who favored corporate action may inhibit others from taking active public stances.

Company Coalition C

Description of the Coalition:

In the fall of 1978, the project team made initial contact with four leading companies in Community C. Though interest was high, activity was not initiated until mid-1979, when the project team arranged a meeting between local leaders and the president of a local Company E subsidiary (with whom project staff were already successfully working). This group of local employees decided to organize and focus on the number and caliber of alternative delivery systems appropriate for Community C. As a group, they were concerned with maintaining high health care standards while promoting competition and cost containment. Coalition C was comprised of management, labor, and health industry representatives.

Personnel from a subsidiary of Company K based in Community C were major contributors to the organization efforts. In the fall of 1979, the coalition appointed the Health Care Task Force, a working committee jointly staffed by the project team and staff from the National Executive Service Corps (NESC). The committee established two subcommittees -- the first, directed in the spring of 1980 to develop guidelines for assessing the need and quality of ADSs; and the second, directed to develop a community-wide employer education effort on the issues of ADSs.

Summary of Activities:

At the request of Company E's subsidiary president, Dr. Ellwood spoke to a gathering of major Community C employees in mid-1979. His discussion of the local health care situation and the potential impact organized business appeared to gel the group's interest into action. The coalition's focus was on local ADS evaluation and support. Project staff assisted in preparation of updates on developing and operational HMOs in the area, options for supporting the growth of a local IPA, and an overview of approaches being taken by coalitions in other parts of the country. During the fall of 1979, the coalition developed standards that HMOs would need to meet to be offered by the business group and communicated their understanding to the rest of the local business community.

In early 1980, a group of employers and providers from Community C were invited by project staff and Coalition C to tour the Twin Cities. The purpose of the tour was to demonstrate a community with active ADS development and business leader involvement. Also during these first few months of 1980, the coalition's subcommittees began in earnest their effort to develop and apply an HMO evaluation protocol and to undertake ADS educational programs in Community C. By the end of Phase 2, these efforts led to development of the Community C HMO Task Force.

Analysis:

The project team is very pleased with this community's innovative approach to active support for alternative delivery system development and growth. The fact that the health care task force in Community C was initiated by local CEOs enhanced its credibility and made the possibility of concrete action more likely. This favorable predisposition was furthered by the personal interest which the CEO of one lead company took in this project. Subsequent task force activities were devised to directly address the major concerns of these employers. These concerns centered around a need to assure themselves that any alternative delivery system which they actively supported would deliver high quality care and would continue to be financially viable. Since these employers did not feel competent to make these assessments, an evaluation protocol was developed to be used both as an educational effort and as a monitoring tool.

Task force members also realized that if the existing ADSs (and any others which might form) in Community C were to be successful, these ADSs would need to substantially increase their enrollment. Thus, support from a large component of this community would be required. Accordingly, the second thrust of the task force activities centered on development of an educational program which will be aimed at the community's small and medium sized employers.

Critical Factors:

Positive:

1) High level officers in five major companies, including Company K, showed interest and commitment.

2) Key representatives of the two key labor unions in the area participated actively.

3) There was coalition consensus on the desire to stimulate effective competition.

Negative:

1) The response of the medical community was predictably negative. Political pressures were beginning to be felt by coalition members.

Company E

Description of the Company:

Company E is a manufacturer of office systems equipment. It is largely non-unionized and places a high premium on employee communications. Its few locations tend to be in small to medium-sized communities; thus, while it is not a large employer, it has a significant influence in several of the communities in which it operates, including its headquarters community. Its relatively small size undoubtedly facilitates access to top management. Company E exhibits a general corporate philosophy of the willingness to take a public stance on issues and to follow up that stance with specific actions. The company has a near monopoly position in its major lines of business.

Summary of Activities:

Company E has proven to be an excellent example of a company in which responsibility investigating health care was clearly assigned to a competent individual, and assigned with the expectation of reporting back to top management. This individual, the director of employee benefits policies, educated himself on the health care situation and, with InterStudy's assistance, evaluated alternative corporate positions and the effect that those positions would have on Company E's health care cost and utilization. His well-documented recommendations for the adoption of a corporate policy were forwarded to chief executive officer, and were timed to coincide closely with a meeting between the chief executive officer and Dr. Ellwood. A supportive corporate posture was subsequently adopted and implemented in several specific, highly visible ways. Major steps included gaining the interest and subsequent involvement of the local industry council in ADS educational efforts, devising excellent HMO offering materials and utilizing them in a supportive offering of a new HMO in the headquarters community, and willingness to speak publicly regarding the company's stance on health care cost containment and the reasons for its support of HMOs. The company also worked to upgrade the quality of HMOs via getting its operating officers on HMO boards and, in one case, supplying an executive to manage an HMO until a permanent CEO could be found.

Analysis:

Company E represents a very positive example of a company which studied the health care situation, adopted a formal corporate stance which included active support for ADS growth and development, and then planned and implemented a number of specific activities to translate that support into positive actions. The personal interest which the CEO of Company E took in this area was undoubtedly the single most significant factor; however, that interest probably would not have been generated had he not assigned specific responsibility for investigation into this area to a competent person and requested feedback.

No significant negative factors appeared in the course of this process. Had the difficulties of the neighboring HMO occurred at an earlier time before support for ADSs was solidified within the company, it could have had a very negative effect. However, coming as it did after not only Company E management was suitably educated but also after the company had taken steps to promote the education of other businesses in the area, this problem was seen as a challenge to be solved by management expertise rather than as proof that HMOs were not viable organizations.

Critical Factors:

Positive:

1) The development of personal interest and knowledge by the CEO.

2) The employee benefits director is interested, knowledgeable, and competent.

3) The company's prestige within the community makes a pro-ADS stance by the industry council a possibility.

Negative:

1) The company does not yet have a data base on health care costs/utilization against which effects of policy changes can be measured. They are aware of this need, however, and intend to correct it.

Company J

Description of the Company:

This lodging-service company is headquartered in the South and has multiple, small (many under 100 employees) locations scattered in communities throughout the nation. As is typical of its industry, Company J does not have a rich benefit package, and its workforce is characterized by an extremely high turnover rate and general low level of education. Since the company's workforce has direct contact with the purchasers of the company's services, Company J expressed a particular interest in promoting the health of these employees as part of an overall corporate action. Policies in areas such as health care and health maintenance organizations are decided and administered centrally, but the company as a whole is quite decentralized, with many franchised operations which are semi-independent.

Because of the small size of local operations, local management was not specialized enough to be aware in general of health benefits or HMO options. The company did have an extensive computerized personnel data system through which it could precisely track the demographics of its employees by age, sex, length of service, pay scale, and location. It was pointed out that this extensive knowledge could be used both to help form the basis of a health care monitoring system and to determine target areas for health education efforts.

Summary of Activities:

Company J's activities in health care cost containment were initiated by an expression of top management interest and were carried out by the director of employee benefits and another person on his staff. The first project was to jointly conduct a review of the company's internal health care situation in major locations to aid development of corporate health policy recommendations which could be carried to top management. These activities were carried out beginning in late 1978 and continuing through 1979.

In the course of this work, the company's need for more reliable cost and utilization data became apparent and the company collaborated with the project team to modify the project team's Corporate Health Care Monitoring System to its own needs. A preliminary report containing the outline of the reporting system and draft recommendations for Company J's corporate policy and specific actions was presented in September 1979, and was revised on the basis of subsequent discussions. Company J received approval to implement the modified health care reporting system in early 1980 and initiated system testing in April and May. Following a wrap-up meeting with project team personnel in March 1980, Company J presented its recommendations to top management and went on record as favoring a formal policy on health care and health care cost containment which included active support for alternative delivery systems.

Analysis:

The project team is pleased with the outcomes of its work with this company. Company J has adopted a corporate policy on health care and health care cost containment which includes active support for alternative delivery systems. Along with this policy, Company J has implemented health education programs to help its employees become wiser buyers of health care services. The company is also implementing a health care monitoring system which will enable it to track costs and utilization for its total covered population. In addition, involvement by benefits personnel in the headquarters community in spearheading the formation of a local employer coalition on health care could lead to similar activities in other locations. Since the company's geographic locations are so small, they are unlikely ever to be a major force for ADS support in a specific community; however, a general corporate emphasis on health and health care could make Company J's support for HMOs a psychologically potent force.

Critical Factors:

Positive:

1) There was a high level of interest in "healthy, happy employees", despite high turnover and relatively low wages.

2) The vice president expected his subordinates to take some action.

3) The company representative assumed the chairmanship of the local businessman's health council.

Negative:

1) Due to low benefits and widely scattered employees, the company is unlikely to have a significant impact on the ADS scene outside of the headquarters company.

Company K

Description of the Company:

This very large manufacturing company is headquartered in a major midwestern city, and, with its competitors, comprises a significant portion of the workforce of the area. In addition, its subsidiaries and divisions jointly constitute a major employment force in several other locations, mostly in the Midwest. Company K has over 20 locations with an excess of 20,000 employees and numerous smaller locations throughout the country. While Company K operations are run on a semi-decentralized basis, policies toward areas such as health care are centrally determined, and HMO policies and offerings are centrally administered.

Health care policies in Company K are a joint concern of the medical department, the employee benefits department (through which HMOs are administered), and the finance department (which sets HMO and other health benefit contribution rates). Company K has a long-standing relationship with Blue Cross, and its regular health care benefits are administered by Blue Cross plans throughout the country. The company has been offering HMOs, particularly on the West Coast, for several years. In 1980, it offered a total of 73 HMOs to its non-unionized personnel. The union exercised its veto power and rejected a substantial number; thus, union employees are offered approximately 40 HMOs. In several instances, HMO rates are substantially (as much as $40) below the company's normal health plan rates; nevertheless, both the union and the company have been wary about sharing cost savings or rebating savings to employees. The company is equally wary of the potential backlash in product sales which might occur if it actively tried to steer employees to one set of providers or another.

Summary of Activities:

The project team met with the employee benefits director and staff several times during Year II of the project and provided assistance in the following areas: handling multiple HMO offerings and administration problems, company evaluations of HMOs, and the rationale for encouraging ADSs and competition within communities. During the course of our work, Company K decided to participate in an employer

coalition in Dayton, Ohio which was formed to strengthen ADSs and encourage a competitive medical care system. They investigated the possibility of a similar activity in Indiana, but decided not to pursue it.

Analysis:

This company's situation illustrates the problem of creating a cohesive ADS policy when corporate responsibility for adoption and implementation of HMO policy is split among various departments. Experience with Company K also demonstrates the difficulty of making decisions and implementing them in a short time frame in such a very large organization. The finance department has experienced problems in working out the details of HMO contribution rates and has had some negative experiences in working with specific HMOs to obtain information from them. Accordingly, its interest in a positive ADS philosophy is not as high as it could be.

As Company K's economic situation has worsened, its attention to all line item expenses has increased, but its willingness to staff an HMO function adequately has probably decreased. Current union contracts give Company K the authority to implement any new benefits or benefit arrangements on a demonstration basis, so long as no benefits are removed. Under the aegis of this authority, the project team hoped to encourage Company K and the union to make a multiple choice offering which is conducted in a positive and mutually supportive framework during the continuation phase of this project.

Critical Factors:

Positive:

1) The employee benefits manager may be moving away from a long-held neutral HMO stance. There is interest in offering HMOs.

2) Concentrations of employees in many communities made it worth the company's efforts to promote HMO choices.

Negative:

1) An unwieldy organizational structure and understaffed benefits department inhibit policy decisionmaking, especially if policies would increase workload.

2) Significant policy changes must meet with union agreement or assent.

Company Coalition L Case Summary

Description of the Coalition:

The receipt of federal feasibility study funds by a group in which the employers in Community L had little confidence provided impetus for those employers to look more closely into the question of alternative delivery systems (ADSs) and their appropriateness for that community health care system. The project team and the assistant vice president of the lead company subsequently began exploring the best way for local employers to become knowledgeable about the health care system in their community and to examine realistic options.

These discussions led to the initiation in April 1979 of a Community Health Care Study Process, a 12-week effort which was designed and staffed by the project team. The committee was constituted of senior representatives of eight major industries in town with one physician and one hospital representative as liaisons to the providers. It met on an approximate bi-weekly basis throughout the spring and early summer and engaged in a simultaneous series of educational efforts and analysis of data on the community which was gathered and refined by the project team.

Summary of Activities:

The lead company gathered a group of eight locally prominent companies interested in exploring the desirability of competition in the local health care delivery system. After an initial meeting, it gained approval to seek the project team's involvement in the study process.

The study process took the form of two parallel emphases. First, data on the health care system of the community was gathered, analyzed, and presented to the coalition. Second, coalition representatives have been exposed to speakers, site visits to two communities, and discussions aimed at familiarizing them with the structure and incentives in the nation's current health system, the nature and types of ADSs, and the desirability and feasibility of competition in health care. These two activities were designed to equip the study group to make a

decision on appropriate actions for the community's health care system in the context of both a general understanding and specific information.

At the conclusion of the study process, the project team presented its findings in a final report and recommended that the corporations commit themselves to support of a competitive health system. Specifically, this could be achieved by supporting the development and growth of ADSs which enhance choice and competition and refusal to support ADSs which are anti-competitive. The study group decided to continue to meet after the formal end of the project. By the project year's end, board membership on the developing HMO was under consideration by at least two of the study group participants, and efforts were underway to persuade a group practice in a nearby community to expand into their community.

Analysis:

Approximately 18 months elapsed between the initial project team contacts in Community L and the commitment by an existing group practice HMO to branch into the community. The project team feels confident that its efforts to educate and motivate employers in Community L were a major factor in the decision of those employers to actively seek competing ADS development and to support those developments. The pre-operational effort to which employers initially objected has since been upgraded through the active participation of coalition members on the board. Thus, the outlook for the community is two new HMOs with support from business.

The community study process in Community L was also very effective in alerting local providers to the interests of the business community in health care cost containment. The hostility of the local provider community toward the federally funded HMO effort and their suspicion of the employer study were clearly negative factors in this community; however, leading physicians were successful in their efforts to influence coalition members and CEOs to "leave medicine to the physicians".

The personal interest of top management in the lead company and willingness of individual coalition members to follow up on the project team's recommendations were key factors in the ultimate success of this project. The responsibility for follow up had not been clearly delineated and, in the absence of this personal interest, implementation steps probably would not have been taken.

Critical Factors:

Positive:

1) Coalition members became increasingly sophisticated; the general education process appears to have been successful.

2) The coalition appeared to be committed to act as a whole and to take a definitive stance; they decided to continue meeting after the formal study ended.

3) The president of the lead company was willing to consider the option of ADS sponsorship.

Negative:

1) The assistant vice president in the lead company was not as strong as the project team originally thought; he was unlikely to take a strong stance.

2) Three companies with the largest number of employees are headquartered out of town; the ability/willingness of local people to commit company to a course of action is uncertain.

Company M

Description of the Company:

Company M, a large utility, has locations in every major city in the nation. It operates under a decentralized organizational principle; thus, policies and practices can vary considerably from division to division. The organization is heavily unionized, but also includes a substantial non-union component. The company has a large research and development component. Company M was in the process of dividing up its operations into non-profit and for-profit segments; thus, a far-reaching reorganization was to take place in late 1980 and 1981, which may have opened the company to new ventures.

Company M had been offering HMOs to its employees for several years prior to our contact with the company. Company M was conscious of the HMOs' positive impact on employee absenteeism and, at least four years ago, began developing a computerized system for tracking company health care costs and utilization.

Summary of Activities:

The project team interacted with Company M on three different levels. Dr. Ellwood maintained an existing relationship with the company's corporate medical director and explored with him the possibility of company-sponsored ADS development. Project team members established contact with personnel of employee benefits, planning, and administration to learn more about their health care monitoring system, absenteeism studies, and corporate HMO policies. Finally, the project team worked closely with a local Company M representative on Community Coalition Q to encourage ADS development in this specific community.

Analysis:

Dr. Ellwood was successful in gaining a platform to address the company's regional medical directors in September 1979 and to attempt to alter their predominately anti-HMO stance. Because the stance is unwritten, no formal action was taken,

but the idea of a company-sponsored HMO continues to receive some consideration, and was seen as a priority for the project team to address in a more direct way in its continuation activities. The project team noted that by Year II the company awareness of the impact of health care on its total operations and its active efforts to address this situation created a climate in which the benefits of encouraging employee membership in HMOs are increasingly likely to be realized.

Possibly the most significant outcome of the project team's work with Company M was the opportunity to use the success achieved by personnel in Community Coalition Q as a model for positive action of other units of the company in communities around the nation.

Critical Factors:

Positive:

1) Concentrations of employees in various communities make influence on local health care system feasible and desirable.

2) The company should be able to track health care costs and utilization in the future; this should enhance interest in cost containment.

3) The corporate medical director believes HMO sponsorship is a possibility.

4) Unions may request increased HMO commitment from the company at the forthcoming bargaining session.

Negative:

1) The company is decentralized; a local unit must be persuaded that it is in its interest to act. (An HMO at corporate headquarters is probably not the best option.)

2) It was apparent that there was no need for the company to act decisively or quickly.

3) Various departments within the company which have an interest in health care (regional medical and personnel, corporate medical and personnel) do not appear to be keeping each other apprised of their activities/interests.

4) The company's HMO policy does not specifically encourage multiple choice in each location.

Company Coalition N Case Study

Description of the Coalition:

A Blue Ribbon Committee on health care cost containment formed in 1978 contracted with the project team to evaluate the feasibility of ADSs for its community. The study effort was funded by five major corporations, and CEOs of those companies formed the nucleus of the group. Included on the committee were hospital administrators, a physician, labor leaders, and other high-level executives of the five corporations. Prior to this effort, the committee had focused on cooperative hospital planning and the possibility of consolidating services to reduce hospital costs.

Coalition N was located in a highly industrialized midwestern city. The only HMO serving the community was a small branch of a plan from a nearby city. In January 1979, a federally funded effort to develop an Individual Practice Association (IPA) ran out of funds. A member of the IPA's board requested financial assistance from the Blue Ribbon Committee to continue this effort. The Committee did not act on the request, but instead decided to focus on the issues surrounding ADSs. The group concluded that a general study analyzing the potential impact of ADSs on the local health care system would provide the information necessary to evaluate the feasibility of ADSs and the possible role of ADS development in containing health care costs.

Summary of Activities:

Representatives from three of the companies traveled to InterStudy in May of 1979 to be introduced to the Twin Cities' medical marketplace and to explore the possibilities of a study in their community. The study, which began that fall, was comprised of two concurrent activities. The project team conducted interviews and collected data on the local community for a final report that examined trends in local health care costs and utilization, the market potential for ADSs, and potential provider linkages and sponsors of ADSs.

At the same time, the staff led the Committee through a series of educational sessions that included site visits to Minneapolis and Denver to talk with HMO executives, employers who offer multiple choice, and hospital administrators about the impact of ADSs on their communities. InterStudy's report recommending corporate support for the development of competing ADSs was presented to a working committee and to the executive committee in December 1979. At that time, the CEO of the lead company expressed an interest in issuing a joint statement with other CEOs which would voice support for ADSs. The working committee endorsed the project team's recommendations and sent those recommendations to the community-wide "Blue Ribbon" Committee in March of 1980. The project team continued to advise the chair of the working committee on strategy options for follow-up, as well as on groups which were expressing interest in initiating pre-operational ADS activities.

Analysis:

The project team believes that the Community Health Care Study Process undertaken with Company Coalition N proved to be an effective way of educating persons to the structure and incentives in health care systems in general and providing them with data on the health care system in their own community. It gave them an informed base for discussions with providers and with potential developers of alternative delivery systems. Nevertheless, while recommendations of InterStudy were endorsed by the working committee, no substantive follow-up activity was initiated. Assignment of local responsibility for follow-up was never clearly delegated; moreover, the community physicians remained at best lukewarm to the idea of ADS development and may have had some influence on the lack of follow-up.

In spite of the CEOs' failure to actively implement the recommendations endorsed, the act of conducting this community study aroused a great deal of interest among health care providers in this community, and attracted the attention of several companies interested in exploring pre-operational activities. Subsequent support by several members of the committee, including high-level corporate executives and labor leaders, were instrumental in initiating development plans for a group practice HMO with insurance company sponsorship.

Critical Factors:

Positive:

1) The study process had the backing of major employers and was incorporated into an existing decision-making structure within the community.

2) CEOs of major corporations agreed to serve on the executive committee of the study; the lead company CEO was particularly enthusiastic.

3) An HMO in an adjacent county had recently branched into the community. While it had less than 1,000 members, its presence helped to focus the attention of the medical and employer communities on this study.

Negative:

1) The community has an aging population and industry has been declining.

2) Employers may be using the threat of ADS development as leverage to secure increased hospital cooperation with shared facilities and services.

3) The lead company CEO was slated for retirement within the year. The other CEOs were strongly affiliated with one or another of the three large hospitals.

Industry-Union Coalition O

Description of the Coalition:

This industry-union joint committee on health care costs included representation from several companies within the industry. The committee, formed as a result of 1977 negotiations, had been meeting on a periodic basis to explore various approaches to health care cost containment while still providing good quality health care for members/employees.

Summary of Activities:

Representatives from the committee discussed with project staff the possibility of InterStudy planning and hosting an intensive two-day seminar for committee members. This seminar, which took place in August 1979, covered the rationale for a competitive health system, the pros and cons of multiple HMO offerings, and labor and employer perspectives on HMOs. Contacts with both union and industry personnel continued after the seminar. Results of these contacts included (1) agreement by the union, during 1980 negotiations, to consider any HMO proposed by the company; and (2) continued interest by the major company in the coalition in pursuing follow-up activities in Phase 2.

Analysis:

While the project team's active association with Industry-Union Coalition O was of a shorter duration than that with most other companies and coalitions in this project, we feel that it was definitely effective in helping to influence the outcome of the 1980 labor negotiations. A positive statement of support for competing alternative delivery systems would have been the most preferable contract wording, but such a dramatic change was not realistic given the varied opinions of the committee members and given other benefit items such as pensions and job security which were of higher priority in this set of negotiations.

One of the project team's goals for its work with the lead company in this effort during the continuation project was to implement this agreement by having the company and the union jointly support a multiple choice offering in a significant employment location. A successful offering of this sort could greatly facilitate ADS support within the company, the union, and other companies in the industry, and could form a basis for further contract improvement in 1983.

Critical Factors:

Positive:

1) The report deadline focused the attention of committee members on the real choices to be made.

2) Both union and management appreciate the need for strategies that bring about long-term cost containment.

3) There are specific locations/situations in which both the company and the union can make a difference.

Negative:

1) Support for competition in health care would appear to be an abandonment of long-term support for national health insurance by unions. Any such stance would require a big education effort.

2) The committee's report will not be binding on management or labor. A strong joint position would probably be given considerable weight in negotiations, but if the report reflects concensus among committee members it may be watered down.

Company P

Description of the Company:

Company P is an acknowledged leader in the office equipment manufacturing industry. A high technology company, it is non-union and has a high interest in maintaining that stance. Its personnel move frequently from location to location and a substantial proportion of its HMO enrollees in several locations are transferred employees who have just moved to the community. The organizational structure tends to be quite centralized. Responsibility for evaluating HMO options had formerly been delegated to local and regional employee benefits personnel, but in 1979 a central HMO department was created and staffed; all HMO options issues are now handled through that office. The office is part of the employee benefits staff which reports through the employee benefits manager to personnel.

Company P places high emphasis on employee relations and employee communications; thus they have gone to substantial efforts to create a film on HMOs and offering materials with which they hope to adequately convey the concept of receiving care through an HMO to their employees. This film is used in conjunction with a mailing to the employee's home. While the company offers nearly 100 HMOs, the enrollment penetration by 1979 was just over 7%, a substantial proportion of which is accounted for by enrollment in the Kaiser Health Plan in California.

Summary of Activities:

In mid-1979, Company P requested the project team's assistance in reviewing the health care systems of 12 of its major employment locations. InterStudy prepared a report which included Community Data Profiles, and recommended that personnel in selected communities take an active stance to encourage preoperational HMO efforts which were underway. Company P subsequently worked with the project team on efforts to track health care costs and utilization and to compare the company's experience in those selected communities with community-wide experience.

Project team personnel also assisted Company P in its efforts to adjust the company's utilization for the age and sex of its covered population, and encouraged the company to compare the experience of their HMO enrolled employees with the experience of other employees. This was subsequently done on a preliminary basis and data appeared to indicate that HMO enrollees have somewhat less absenteeism than do other employees. Company P is interested in pursuing these studies further.

Analysis:

Company P already has a reputation as a "pro-HMO company", in large part because of the sophistication of its offering materials and its policy of offering all federally qualified and state certified HMOs. However, this reputation is not matched by significant enrollment penetration, and it is that situation which the project team wanted most to alter. Because of the potent example value of Company P, any actions it takes or changes in its stances would have a significant national influence.

The general level of understanding of health care and interest in health care among the employee benefits planning and operations staff is a positive factor, as is the apparent degree of cooperation and communication between those two divisions. In the specific case of Company P, the centralization of HMO activities further enhances the possibility for studies which could document the effects of HMO membership and for corporate-level decisions to support HMO development efforts in specific communities.

The major factors inhibiting such movements at this time appear to be a long-standing policy of not allowing outside vendors of any sort to make presentations on company property, or to commit company time to such an enterprise. The inhibiting factor in positive community action for ADS support is a general corporate attitude of not wishing to appear to be the dominant factor in any aspect of a community in which it is the major employer. However, there is also a Company P tradition of community service by employees, and it may be possible to apply this tradition in specific situations to promote HMO development.

Critical Factors:

Positive:

1) The company has made a commitment of time and funds to the HMO Department.

2) The company has adopted a policy of favoring multiple options for employees wherever possible.

Negative:

1) It remains to be seen whether the HMO Department will be able to track cost/utilization changes, thus providing objective evidence to support/disprove the cost effectiveness of a pro-HMO policy.

2) The company was reluctant to allow HMO presentations on company time/property.

3) The company preferred a low profile approach in major employment communities.

Company Coalition Q Case Summary

Description of the Coalition:

Multiple coalition activities focused on health care system reform and health care cost containment have surfaced in this community since late fall of 1978. The project team worked with this committee and its chairman to help members recognize the very high level of health care costs and utilization in Community Q, and to realize the potential power which the business community had to effect change in the system. Because of the presence of an academic medical center and the use of Community Q as a regional referral center, the local provider community had habitually attributed high cost and utilization statistics to out-of-area usage. Project team members helped the local Chamber of Commerce's health care committee to realize that health care cost and utilization were high even when this out-of-area usage was factored out.

The interest generated by the activities of this committee in the community led to the formation of two other committees focused on health care. The American Medical Association decided to use Community Q as one of its demonstration communities and initiated a joint employer/provider committee which was headed up by a local representative of Company M. This committee initiated a thorough exploration of hospital-specific utilization data and, in the spring of 1980, devised a plan for voluntary utilization control which was submitted to the county medical society for its acceptance.

In addition, in December of 1979 InterStudy and the National Executive Service Corps (NESC) jointly helped initiate a CEO-level committee on health care costs. This committee was incorporated early in 1980 into the local Chamber of Commerce structure such that the chamber's health committee would form a working committee for the CEO effort.

Summary of Activities:

Chamber of Commerce representatives initially contacted the project team in late 1978 to request a speaker for the health care committee. That initial visit put

the project team in contact with the committee chairman, to whom information and educational/planning assistance have subsequently been provided. The project team has made additional corporate and provider contacts through both NESC and other target business. A status report was drafted by the project team; it was submitted to the chairman of the employer committee in draft form in May of 1979 accompanied by suggestions for next steps.

At the request of the Chamber of Commerce committee, a follow-up presentation was made to the alternative delivery system's subcommittee. A report on developments was forwarded to NESC to encourage contact with the CEO of a target firm. Detailed background information was collected in October 1979 in support of efforts to interest the company in ADS development. A report was developed and presented to the CEO prior to hosting a meeting of key executives from local firms. A meeting was held in December 1979, and the project team assisted in the formulation of follow-up activities.

Analysis:

The project team's contacts in this community tended to remain of an unstructured nature. While this may have hampered our efforts somewhat, it also afforded us an opportunity to relate with all three committees without being too closely identified with any one of them. Involvement at the CEO level appeared to be a clear signal to the medical community that some change was going to be required. The CEOs' increasing interest in cost containment and alternative delivery systems undoubtedly contributed to the medical society's willingness to consider the institution of voluntary inpatient utilization controls in mid-1980. The medical community may regard its effort as one that would obviate the need for ADS development; however, it is not clear that the business community agrees.

Considerable interest in the initiation of alternative delivery systems has been generated as a result of the activities of these three committees. By 1980, Community Q had one operating alternative delivery system, and a major insurance carrier announced plans in the spring of 1980 to develop a second alternative delivery system. At the end of Phase 1, it was difficult to

determine the long-term impact of the project team's activities with the various coalitions in Community Q. It was clear that any outcome in terms of employer support for ADSs or development of multiple competing ADSs was attributable to many forces, of which the project team was one.

Critical Factors:

Positive:

1) The local CEO was knowledgeable and interested.

2) An employer health care group and ADS subcommittee existed with key representatives from Company M and Company O.

3) Major employers and providers in town who indicated interest in exploring a pro-ADS stance were contacted.

Negative:

1) Concerted employer action or stance was unlikely to work unless the major employer participated more actively than in the past.

2) Various groups from within and outside the community had different ideas about desired outcomes.

Company R

Description of the Company:

Company R is a very large retailer with sizable locations throughout the country. As is characteristic of other companies in its industry, Company R has a relatively low level of employee benefits in general and health care benefits in particular. Nevertheless, the company has offered HMOs since the mid-1970s and does employ a specific person within corporate employee benefits offices who administers these offerings on a central basis. While local employee benefits personnel are involved to some extent in HMO offerings, they look for major guidance and support to the headquarters office, which conducts all negotiations with HMOs. Of significance is the fact that there actually is limited HMO enrollment of Company R employees in their headquarters community.

The project team was aware from other sources that an insurance subsidiary of Company R was interested in exploring a future role in the health care industry by building on its insurance background. The project team was also aware that certain outlets of the company were already delivering some types of medical services on a fee-for-service basis; thus the development or sponsorship of an ADS was of some interest within the company.

Summary of Activities:

Through a third party, the project team was able to make contact with a vice president of Company R and to arrange for a presentation and discussion in the fall of 1979. The session was a combination of education, of exploration of this company's interest, and discussion of areas in which the project team could be of assistance in developing health care policy. The possibility of ADS sponsorship was discussed at this time and appeared to be quite well received in that meeting and follow-up conversations. At the conclusion of this discussion, the Company R vice president suggested that he consult with his colleagues before any further action or considerations were made. Despite continued contact by project staff, Company R's deliberation continued until fall of 1980. During this period, the project team did not have an opportunity to establish ongoing

rapport with more than one person in the company, nor was it able to encourage use of its assistance by company personnel. In August of 1980, Company R determined that it did not have the resources to pursue exploration of its corporate health benefits policy at that time and announced that decision to the project team. It appears likely that the company's economic difficulties played some role in this decision.

Analysis:

Activities with Company R did not prove to be very satisfactory or very extensive. The project team was attracted by the apparent interest of Company R in participating in the project because of its size, multiple large locations, expertise in retailing, and national prominence. While the project team was encouraged by initial interest at the vice president level and by early conversations in the fall of 1979, this promise was not realized, and the company delayed a decision on future action throughout the winter and spring of 1980. We were hampered in part by the company's long time frame for making a decision on whether it wanted to give time and attention to consideration of health care policy and/or health care venture issues. The positiveness of the company's initial response, the relatively high level of the contact, and the project team's own interest in working with this company appeared to be favorable factors. However, they were outweighed in the end by the vice president's inability or unwillingness to gain sufficient support for pursuing discussions, and his apparent unwillingness to allow the project team to work with him to help gain that support as we have done in other companies. The project team was not successful in gaining access to employee benefits personnel and thus was unable to establish a lower level contact and work upwards through the company, as has been effective in other target companies.

Critical Factors:

Positive:

1) The company has an active interest in offering HMOs.

2) The company is recognized as a leader in its metropolitan headquarters location and many other locations.

3) The company already is involved in delivering at least three types of health care-related services.

Negative:

1) There is limited interest by top management at this point.

2) The company does not appear to have an overall, coordinated approach to health care issues.

3) Vice president appears to need consensus from several other areas of the organization before project activities can proceed further.

Company S

Description of the Company:

Company S, a major figure in the chemical and processing industry, has its largest number of employees and its corporate headquarters located in the same community. As the principal employer in this community, Company S's policies and actions hold significant potential impact over the local health care system. Though individual operating plants in other locations have noticeable independence, corporate policy on health care issues is centrally determined and administered. Consequently, policy changes established at the headquarter community level may well affect change in other communities. At the time of Phase 1 activities, Company S was maintaining a long-standing carrier relationship with Blue Cross, and at the time was the largest account held by that regional Blue Cross plan.

Company S had experienced high health care costs for several years and contracted with outside groups for a community health system study in 1976-77 and for an HMO study in 1977. The feasibility study indicated that either a group practice or an IPA could probably operate successfully. Questions about the validity of enrollment projections and about the relative desirability of those two models led to a subsequent, community-wide survey of the preferences of employed persons in the area. Survey results received in 1979 indicated that the number of persons attracted by a group practice HMO model made this model a viable option. In mid-1979, finance personnel were called upon to assist employee relations and benefits personnel in developing recommendations to the president on whether or not the company should support and/or sponsor an HMO in its headquarters city.

Summary of Activities:

Clearly, Company S had been aware of the need for health care cost containment since 1977, and InterStudy's first joint effort with them involved a 1976-77 community health system study, reviewing local prospects for HMO development.

Following this effort, InterStudy worked with Company S's employee relations manager on a National Chamber Foundation task force in preparing a series of publications on health care. Because of this ongoing relationship, the Company S cost containment committee looked to the project team for assistance in deciding whether and how to approach supporting local HMO development.

In the fall of 1979, the project team was able to provide company representatives with: (1) available data demonstrating the cost-effectiveness of group practices; (2) reasons why a major employer in the company's position should support HMO development; (3) experiences of businesses in the Twin Cities which have supported HMOs; and (4) pros and cons of alternate means of developing an HMO (e.g., with a consultant, joint venture with an insurer, in-house, with or without federal funding). Also during this period of deliberation, project staff encouraged the involvement of Company S financial personnel to consider the cost-saving potential of ADS development. This overall decision process resulted in a cooperative effort by Company S staff and project staff to formulate a report to corporate management recommending support of ADS development. This report was not acted on directly. However, the alternative approach of working with local physicians to encourage voluntary control of utilization was adopted and initiated in the spring of 1980. There was also growing interest by Company S in a joint HMO development venture with major insurance companies. Thus, while the actions of Company S may not result in a company-sponsored or supported alternative delivery system, the company's active investigation and its impact on the community appear to have generated sufficient interest to attract pre-operational activities by others in the headquarters community.

Analysis:

The company appeared to be reasonably well aware of its internal cost and utilization situation, and had paid for three consultant studies, all aimed at the possibility of HMO development. Former top management had an active interest in health care and in health maintenance organizations. This interest was communicated to employee relations, which was given the primary responsibility for investigating options on behalf of the company. While current top management is aware of the health care situation, it is not as actively supportive of HMOs.

However, Company S illustrates the difficulties any outside group has in trying to speed up the time frame within which a company deliberates and takes action. It is difficult to determine why events have been so slow moving within Company S. While investigation of HMO sponsorship has been a long-term concern, it appears never to have been a high priority of any one person who had a vested interest in seeing a positive outcome. Through its contact with InterStudy and other consultants, personnel in Company S have become reasonably well aware of events in other cities, including the multiple-HMO situation in the Twin Cities and the results on competition. They have also studied company-developed HMOs such as the Winston-Salem plan. Following the presentation of the December 1979 report of the committee to top management, it does not appear likely that Company S will actually sponsor an HMO in its headquarters community. Nevertheless, as previously noted, its investigation activities carried out over the last four years have increased the level of awareness of the medical community significantly and have interested other parties, specifically Blue Cross, in HMO development.

Positive factors that may eventually prove important in this company's activities were the decision to include finance department personnel in the late 1979 deliberations and preparations for the top management report. These personnel immediately grasped the cost-savings potential of an HMO and the potential of competition to alter the structure and incentives of a community's health care system. The project team feels that the opportunity to educate these persons was a valuable one and that their influence in subsequent company activities may be substantial.

Critical Factors:

Positive:

1) The company has perceived the need for action on health care cost containment.

2) An organization and staff has been established to investigate alternatives.

3) ADS development is being considered as one of the most promising approaches to pursue.

Negative:

1) The company has a long decision process and specific action will likely take more time.

2) Considerable back-up support for the decision is needed and current state-of-the-art evidence may not be sufficient.

3) Current top management does not appear as supportive as former management to ADS development.

Community Coalition T

Description of the Coalition:

Efforts to start joint employer activity were undertaken by the CEO of the lead company in Community T in 1976; these efforts were unsuccessful. However, in 1977 a coalition of local business interests as well as local providers was formed. Due to the makeup of the coalition, reaching consensus and taking actions have been difficult.

Summary of Activities:

The project team provided assistance and consultation to coalition efforts throughout the winter and spring of 1980. These activities included tours of the Twin Cities' medical marketplace for various employer and provider representatives of Coalition T; presentations to various elements of the community; and guidance for an ADS feasibility study. The continued unwillingness of local physicians to be involved indicated that a group model HMO was not a feasible option in Community T in 1980 unless an already operating group model HMO were to branch into the community. The CEO of the lead company has continued his efforts in this regard since that time.

Analysis:

Community T provides an excellent example of the extent to which community providers who see no need for change can hinder the development of alternative delivery systems even in the face of concerted employer action. It takes a substantial educational effort before employers feel confident enough to challenge the physicians' declarations that they are simply providing very high quality care and the community should be grateful for their efforts. Local physicians have proven very resistant to change, but as the business community has become more aware of the very high level of their health care costs and utilization in Community T as compared to other communities, their insistence on the need for change has grown.

InterStudy has not provided additional help to Community T under this grant. However, with InterStudy's help, funds were obtained for a feasibility study which showed a group practice HMO to be viable in the community. The CEO of the lead company and others are currently in the fundraising and planning phases prior to a group practice HMO opening within the next 18 months.

Critical Factors:

Positive:

1) The target company CEO and other business leaders were very supportive.

2) A coalition of interests appeared committed to act.

3) The HMO feasibility grant funds were available to support the study effort.

Negative:

1) There was a lack of group practice activity in the community which could provide delivery capability for the ADS model preferred by business representatives.

2) There was a sustained resistance from local physician community to ADS development.

D. Conclusions for Phase 1 (Years I and II)

During the course of the first two years of the project, the project team undertook numerous activities to stimulate corporate support for ADS development (speeches, articles, promotional efforts in conjunction with OHMO, etc.) and worked directly with 15 corporations or coalitions of employers. This section describes the outcomes of our efforts and a brief analysis of the factors that both aided and hindered our progress with the 15 target companies and coalitions.

1. Project Outcomes

The four major objectives for the project provide a useful framework for considering the project outcomes:

Objective 1: *Establish an ADS/Business Information Center which identifies and reports on ADS activities taking place. Use the Information Center to track progress in corporate sponsorship of ADSs, to serve as a basis for selecting target businesses, and to assist the Office of HMOs (DHHS) in its data gathering and promotional efforts.*

The project team met this objective. The ADS/Business Information Center took a somewhat different shape than anticipated, however, since the Division of Program Promotion (OHMO) assumed responsibility for the "Hotline" set up to respond to inquiries from corporations as a follow-up to the Secretary's breakfast.* The project team, therefore, worked even more closely with OHMO than anticipated. Information from the Center assisted the team in selecting the target corporations and generating materials used in working with the companies.

Objective 2: *Identify six (6) corporations or groups of corporations and community interests in Year I and nine (9) in Year II that are most likely to be instrumental in supporting ADS formation and growth, based on key characteristics and health care situation (i.e., excessive costs, corporate interest, labor intensity, geographical concentrations, etc.).*

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*Secretary Califano, at a special breakfast session, had urged top corporate executives to actively support HMO development.

The project staff did select and work with 15 corporations or groups of corporations. In retrospect we believe we may have selected poorly in a few cases. Some of the companies seemed predisposed not to take the positive actions we sought, in others the process took much longer than expected. One outcome of the project was the identification of positive and negative internal factors in trying to move a company toward a pro-ADS stance (see discussion under Objective 4).

Objective 3: *Undertake studies in target companies to carry them to the stage of a corporate decision to actively support and/or sponsor ADS formation and growth.*

ADSs Directly Attributable to this Project

a. Dayton, Ohio -- Although two HMOs were in active preoperational status at the beginning of the project, the subsequent activities of the local coalition have strengthened both plans and led to sizable initial enrollments.

b. Stamford, Connecticut -- The project team's work with Company E and through them with the Stamford Area Commerce and Industry, were important factors in enabling a group model HMO to initiate operations in Stamford in July 1979.

c. Preoperational ADSs in:

Birmingham -- The work of InterStudy and the National Executive Service Corps resulted in an educated and supportive group of top executives and middle managers. In this conducive climate, Prudential announced in spring 1980 its decision to develop an HMO in Birmingham.

Des Moines -- Project staff encouraged and assisted the formation of a business group which subsequently voted to directly sponsor the development of a group model HMO.

Akron -- Activities of the Akron Working Committee of a Blue Ribbon Task Force attracted the interest of several potential HMO sponsors, including Nationwide Insurance and Blue Cross.

ADSs Indirectly Attributable to this Project

a. Quad Cities -- A Deere-sponsored HMO became operational in May 1980. Dr. Ellwood and other project team members have provided ongoing contact and support to Deere in this effort.

b. Champagne/Urbana -- Dr. Ellwood provided preoperational consultation and assistance to a group practice sponsored HMO which became operational December 1979.

c. Preoperational ADSs in:

Rockford -- The project team provided information, contacted local industry, and supported the HMO feasibility analysis of a medical group. The decision to form an HMO was made in summer 1980.

Oklahoma City -- Efforts by InterStudy and NESC to stimulate local business support for HMO formation appeared by late 1980 to lead to a preoperational effort.*

Fort Wayne -- Work with a local coalition led to the extension of a nearby HMO into the Fort Wayne area.

Companies Which have Adopted and Implemented a Positive ADS Policy, Attributable to this Project

The project team was successful in persuading three individual companies and four coalitions of employers to adopt pro-ADS and pro-competition policies. The coalition efforts occurred in communities where there was no, or very limited, HMO activity but where planning or development of an HMO was underway. In each case, CEPs and top level executives of the local companies realized they needed to develop a formal posture on HMOs for their community, and decided to study the issues through a joint employer coalition. The project team provided interim staff support, speakers, and site visits for the coalitions in Akron, Dayton, Des Moines, and Fort Wayne. At the conclusion of the study, the coalitions endorsed HMOs as a positive alternative to health care financing and delivery. In Des Moines and Dayton, the coalitions have continued to play an active role in shaping ADS development with strong CEO level involvement. In Akron and Fort Wayne, the coalitions disbanded, but representatives of individual companies became active supporters of HMOs that are now operational.

The three companies which adopted pro-ADS stances included Companies A, E, and J. The project staff conducted a health benefits audit for A and J and provided direct assistance in developing a corporate policy statement on health care cost containment and ADS. Dr. Ellwood, through contact with the CEO and

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*Subsequently, Prudential decided to sponsor an HMO with a local group practice.

benefits manager of Company E, was instrumental in the adoption of an active program of support for HMOs, including the development of very positive HMO offering materials, in kind staff support to an HMO in Company E's headquarters city and putting HMOs on the agenda of the local industry council. This company's very active stance has attracted national attention and has proved to be a potent model for other companies.

Objective 4: *Document the methodology employed in the decisionmaking processes of target businesses in a manner that will allow other businesses to make appropriate policy decisions on ADS support/ sponsorship.*

One important product from Phase 1 is a three-part methodology which has been used since the completion of the project by other corporations and persons working with corporations on health care alternatives. The reports which comprise the methodology are as follows:

Design for a Corporate Health Care Monitoring System -- a prototypical employer's health care information system and a general methodology for the definition and implementation of such a system.

Design for a Community Health Care Study Process -- a methodology for a coalition study and decision process which could be widely used by business health care coalitions.

Discussion of the Corporate Decision Process to Support Alternative Delivery Systems (part of the Year II Annual Report) -- an overview of the factors which have appeared to be common facilitating or inhibiting forces in the decisionmaking of several of the target companies (see below).

2. Factors that Influenced the Outcomes

The factors identified by the project team as significant forces are listed in abbreviated form below. The positive factors are listed in general chronological order as a company moves from "interest" to ultimate implementation. The negative factors can appear at any time; chronological listing was not found to be important.

FACTORS INFLUENCING THE CORPORATE DECISION MAKING PROCESS:
PHASE 1 (Years I & II)

Significant Positive Factors

1. One person within the company who is interested in long-term health care cost containment strategy. (not just assigned the task)

2. Assignment of responsibility for investigation into corporate alternatives and request to report back with findings to a superior. (complementary to #1; the higher that person's position, the better)

3. Interest on the part of the chief executive officer. (especially if the CEO initiates the study or action)

4. Access to persons, organizations, or materials which convince the responsible person of the appropriateness of the corporate posture of support for ADSs. (paucity of materials right now to support the competition notion)

5. Assistance in convincing others within the company of the appropriateness of a pro-ADS stance. (outside presenters, other corporations, "tours" of competitive communities, etc.)

6. Willingness to commit to a recommendation of support for ADSs. (person carrying the message to his/her own top management must be willing to commit to ADSs as a long-term, central strategy)

7. Ability to influence top management to both adopt a stance and act on it. (best guarantee of action is to stimulate the personal interest of the CEO)

8. Specific assignment for policy implementation to a very competent person. (follow-up must be assigned to someone the CEO knows will act)

Significant Negative Factors

1. Absence of one or more of the above positive factors.

2. Active opposition by the medical community. (especially if physician friends persuade the CEO or other top management that HMOs will have a negative effect)

3. Opposition by middle or top management.

4. Prior or conflicting company policy. (e.g., a "low profile" policy or linkage to a local hospital)

5. Corporate risk aversiveness. (company may fear everything from bad press to a boycott of the company's products)

III. FINAL REPORT FOR PHASE 2 (Years III and IV)

A. Statement of Objectives and Approach

The original purpose of the project -- to promote the development of business-sponsored and business-initiated Alternative Delivery Systems throughout the country and to encourage the adoption of a corporate position of active support for ADS growth and development -- remained unchanged during Phase II. However, the objectives and activities for Phase II were modified from the original proposal to take advantage of the experience acquired and the contacts developed over the first two years of the project.

The major objectives for Phase 2 of the project were as follows.

Objectives:

1. Collaborate with five leading companies to select a major target community (and one to two secondary targets, if they choose) in which that company is a dominant employer, and track those five communities intensively over a two-year period.

2. Support the actions of five lead companies to catalyze change in the health care delivery system of one community in which it is a dominant employer.

    a. Help each lead company organize and carry out a local employer coalition to investigate the local health care delivery system and determine whether business support of ADSs is appropriate and desirable.

    b. Provide staffing for employer coalition activities (education of employers, data gathering, analysis, and development of consensus and recommendations).

    c. Explore with and recommend to each company ways in which it can increase the cost effectiveness of the health care dollars spent for both employees and retirees, both in the primary community and in the company at large.

3. Examine with lead companies the desirability and practicality of direct ADS sponsorship and of innovative retiree demonstration contracts.

    a. Explore with each company in outline and with two to three companies in detail the desirability and practicality of actually developing a company-sponsored ADS for the dual purposes of stimulating competition in the community and creating a laboratory for applied research that will help the company develop and test new products and systems.

    b. Investigate the legal and economic issues, for the companies and for HCFA, associated with various methods of offering retirees the option of HMO enrollment or other capitation arrangements on a demonstration basis.

Overall Approach

Formal day-long planning meetings were held with the five corporations early in the project year. Each meeting included a review of the three objectives outlined above, an overview of the company's health care cost containment strategies and policies, and HMO experience and policies. Also at this time, company representatives started the process of determining specific activities to be carried out for each objective (i.e., selecting a target community, methods of working with coalitions, cost containment initiatives, etc.). Objective 3 was discussed at this meeting, but further activities were postponed until work was underway on the first two objectives.

Following the initial planning meetings, InterStudy staff was in close contact with each company to finalize the activities each company would be involved in. Many activities were company-specific and are described in detail for each company in the section which follows. Certain other activities began with the same approach for each company -- two conferences, retiree demonstration feasibility planning, and HMOs as a corporate venture. In all cases, a program was developed for the two years which tailored to each company's concerns and meeting the three objectives above. The bulk of time during Year III was spent working with the companies in their selected Target Cities and with local coalitions. This work was continued in Year IV. Also in Year IV, a number of background papers were developed for companies to consider the desirability of a retiree demonstration and sponsoring an ADS. These papers were used as a basis for discussion with the companies as they considered further steps they might undertake.

B. Activities

Activities during Phase 2 were individually tailored to each company. However, certain topics were of interest to all companies and seemed ideal for joint discussion and exploration. Early in the project it became clear that these five companies were eager to hear from each other on the potential for coalition activities and the state-of-the-art in health care data monitoring systems. In response to this interest, InterStudy organized and hosted two seminars on these topics for the five companies and other interested corporations who were leaders in these areas. Further, feasibility and education efforts regarding both innovative retiree demonstration projects and corporate sponsorship of ADSs led to

a number of questions and concerns common to all the companies. Project staff developed background papers and supporting data which could be used by all the companies as they considered potential activities in these two areas.

The section which follows describes those four areas of activity common to all five companies. The next section is organized by company and details project team efforts with each, and outcomes in all three of the major task areas: communities, cost containment activities, and retiree demonstrations and ADS sponsorship.

1. Joint Activities with the Five Companies

Seminar for Health Care Coalitions, June 1981

InterStudy sponsored a seminar for members of health care cost containment coalitions at our facility in Excelsior. While the seminar was primarily funded by the Pew Foundation, additional financial support came from this grant. We invited members from 17 of the more than 40 coalitions around the country, including field and headquarters staff from four of the five lead companies. In particular, two of the target communities, Endicott, New York and Philadelphia, Pennsylvania, were represented by our local project contacts from Company P and Company M; and headquarters representatives from Company K, Company P, and Company O were in attendance. The opportunity to talk with the corporate representatives both formally and informally about local initiatives was an invaluable aid in providing ongoing assistance.

Michael Gartner, Editor and President of the *Des Moines Register and Tribune,* gave the keynote speech, "Business Efforts to Influence Local Health Systems -- What We've Learned in Des Moines". As the chief executive officer of a firm employing 1,200 people and a prominent business leader in a Des Moines coalition, Mr. Gartner was uniquely qualified to deliver the keynote. He emphasized the importance of involving top corporate officers in coalitions, and in describing the history of the coalition in Des Moines he provided a useful framework for the seminar sessions.

Following Mr. Gartner's speech, three coalition presentations were given: (1) Getting (and Staying) Organized, (2) Defining Problems and Setting Goals, and (3) Coalition Action Strategies. These sessions were structured to address the main concerns of coalitions. Six representatives of five different coalitions gave the presentations so that participants could learn from the experiences of their colleagues.

The first day of the seminar concluded with a series of discussion sessions centered on the topics of the three coalition presentations. Moderated by InterStudy staff, the sessions offered an opportunity for informal discussion on issues and questions raised during the presentations.

Three workshops were conducted on the second day of the seminar: (1) HMO Evaluation, (2) Measuring Change, and (3) Hospital Utilization Review: A Technique for Coalitions. The workshops were designed to provide practical assistance to coalitions.

For the first workshop, Oscar Salyer, President of Local #175 of the Utility Workers Union and a key member of the Dayton HMO Task Force, and InterStudy's Jerry Meier described the HMO evaluation protocol they developed to assess the two prepaid plans in Dayton. They reported that the evaluation process has helped the Task Force and the HMOs work together to improve their performance. The workshop sparked a lively debate; some participants expressed their concern that such a process might be manipulated by the opponents of HMOs.

Coalitions typically are very concerned about developing data systems to measure the impact of their efforts on local health care utilization and costs. Linda Ellwein of InterStudy presented suggestions for a community health care monitoring system which would provide for pooling the utilization and cost data of major local employers and compiling area-wide indicators of resource levels, cost, and use of services. The paper developed for the seminar will be made available to coalitions we are assisting under this contract and is included in the Appendix.

The final workshop dealt with hospital utilization review as a relevant short-term cost containment technique for coalitions. Jan Malcolm of InterStudy presented an overview of existing utilization review systems

based on a recent study of HMO utilization control techniques. Don Hutchinson, from St. Louis Park Medical Center, discussed that medical group's program. Finally, Dr. James Kenney discussed the details of the Minnesota Coalition's private utilization review strategy being undertaken by Twin Cities' employers.

In sum, the seminar provided a unique opportunity for the participants to learn from the experiences of their colleagues. It was particularly educational for representatives of new coalitions.

Seminar on Corporate Health Care Monitoring, May 1981

All five companies had expressed substantial interest in increasing the cost effectiveness of their health care dollars. However, to get more for their money corporations must understand where the money goes, what services are provided, and how they are provided. InterStudy sponsored a seminar in Excelsior, funded under this project, where representatives from the five firms as well as other interested corporations could discuss the goals of their health care monitoring systems, techniques being used, problems encountered, and progress to date.

The first morning consisted of five speakers detailing specific aspects of their corporate health care monitoring experiences. The afternoon was devoted to open discussion of corporate health care strategies. The agenda for the second day was designed for corporate personnel with specific responsibility for data collection and/or analysis. A total of 17 people from 10 companies, including Company M, Company P, Company V, and Company O, attended the 1½-day seminar.

Ed Lund, Vice President of Administration at Honeywell, gave the keynote speech, "Corporate Commitment to Health". Mr. Lund first detailed the rapidly rising medical costs at Honeywell and then reviewed steps his company is taking to hold down these costs. The major programs are (1) developing a medical claims data base, (2) promoting alternative delivery systems offering over 40 HMOs nationwide, (3) offering wellness and health promotion programs, and (4) actively participating in business coalitions. Mr. Lund stressed that accurate information is necessary to define the problem, develop solutions, and finally measure the effectiveness of the solution.

Corporate presentations were then given, focusing on four different aspects of monitoring health care. Richard Van Bell, Deere & Company, discussed the corporate decision to develop a monitoring system. Deere formed a health care department in 1977 to be responsible not only for claims processing and data development, but to use the data to interface with providers, perform long-range planning functions, and design appropriate benefits. Deere plans to expand the use of this data management capability in the future to emphasize rehabilitation programs, alternatives to current procedures, and health education programs.

Dr. Don Johnson, AT&T, described the in-house analyses of carrier data through AT&T's HUMS system. This system, based on output from the Blue Cross claims processing system, became effective in 1978. HUMS enables AT&T to look at utilization and costs for about 10% of its employees and dependents. The company has been pleased with the results and is implementing a company-wide system in the near future; uses will include planning, budgeting, negotiating, and monitoring.

George Henshaw, U. S. Steel, spoke about using a carrier to collect and analyze utilization data. Blue Cross developed programs to track hospital utilization at 11 major locations. Results are used to suggest future courses of action.

Dr. John Mitchell, AT&T, explained studies which compared absenteeism between HMO and non-HMO members. These studies were undertaken to see if the lower hospitalization rates experienced by HMO members also resulted in lower absenteeism rates. Results were mixed on small samples at five locations.

The remainder of the seminar consisted of discussion sessions covering health care policies and objectives, techniques to meet these objectives, problems encountered, and accomplishments to date. While all the companies agreed that health care costs were definitely a problem, there were varied opinions as to how to solve this problem. Some corporations relied on carriers to change a local situation, others went in directly via a coalition, and others worked by themselves using techniques ranging from confrontation to negotiation.

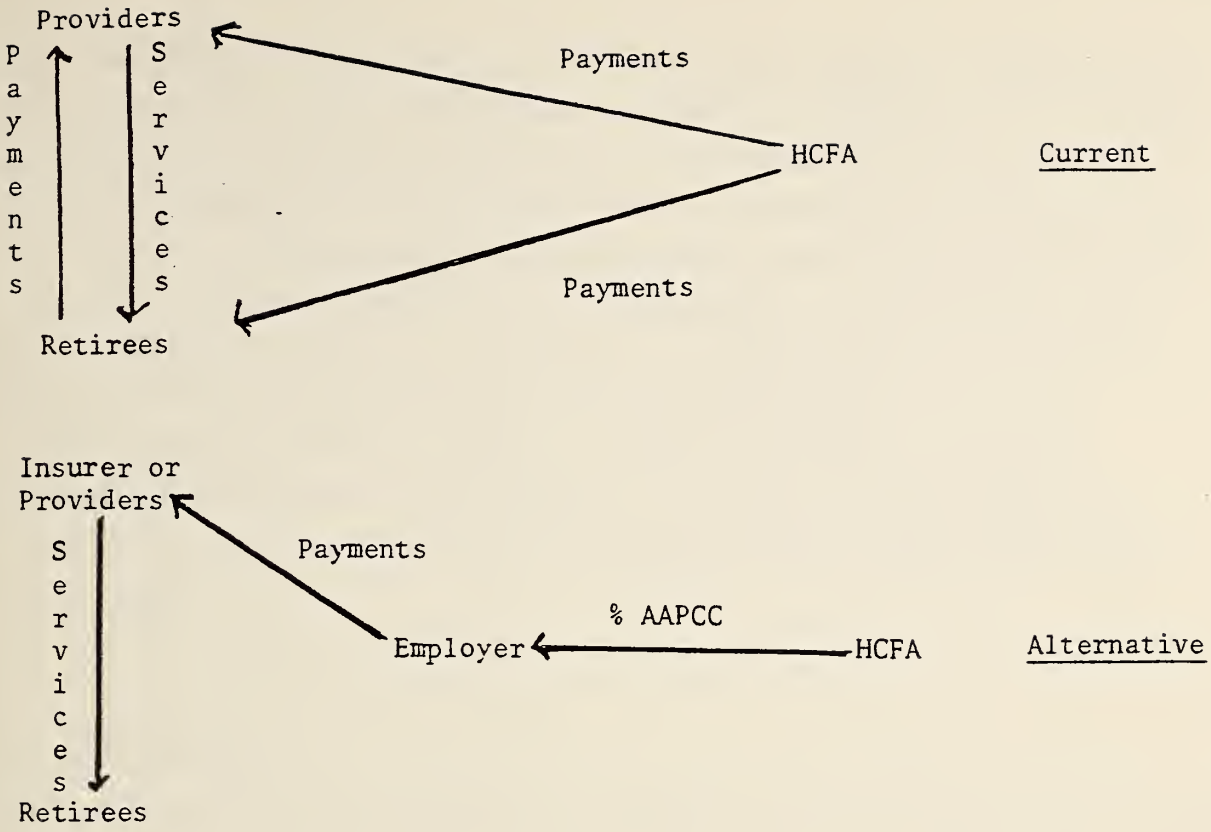
The conversations were candid; all the companies were anxious to share information and learn what the others were doing. It was enlightening to some to learn of the activism of other companies and of the confrontation tactics used in specific situations. Most important of all, this seminar provided the attendees with a number of contacts with whom they could discuss problems and possible solutions, and perhaps approach some issues on a joint basis.

Retiree Demonstration Project

It was necessary to develop background information pieces and spend considerable time educating the five companies about the potential experimental programs that could be developed for their retirees. The general background pieces and supporting work is described below.

The initial undertaking was to set the general framework for a retiree demonstration, i.e., why should a business undertake such a project and how could it be approached. A paper entitled "Medicare and Business" addressed these issues. A company might want to undertake an innovative retiree demonstration project to enjoy immediate cost savings via more cost-effective delivery of care and administrative simplicity and/or to provide better services to retirees by reduced premiums, increased benefits, and decreased paperwork. The general approach suggested in this paper was that business might receive a payment from the Health Care Financing Administration (HCFA) and then negotiate an arrangement with an insurer or HMO to provide Medicare benefits. In essence, instead of each beneficiary negotiating each service separately with providers, the company would play an intermediary role as shown in Figure 1.

Once the companies understood the general problem and approach, specific options and issues needed to be addressed. Two papers were developed to help companies with this process, "An Outline of Options" and "Options and Issues". These papers set forth decision areas and some alternative directions these decisions could take. The decision areas set forth were: benefit package, eligibility, capitation rate, risk management, providers, marketing, lock-in provisions, and administration.



Meetings were arranged with the three interested companies (K, O, and X) to discuss current retiree programs, objectives under the proposed demonstration, staff who would be initially involved, and the issues and options presented in background papers described above. At the end of the meeting, an agenda of activities and research to be completed in the next several months was established. At this time, the companies were given "Suggestions for a Business/ Medicare Feasibility Study", a paper which set forth specific data to acquire, policies to consider, and tasks to undertake. Based on concerns voiced by all three companies, HCFA was contacted to determine its preliminary position regarding benefit levels, reinsurance, lock-in, capitation rate, and certain administrative problems. The general attitude of HCFA appeared to be that there was flexibility in each of these areas and that any reasonable proposal would be considered.

After the initial meetings, the project team provided support and assistance to each company on an individual basis. This work is detailed in the company case histories below. After further internal discussion, Company X decided not to proceed further. As is detailed in the company description which

follows, Company X preferred to use an "insurance approach" rather than an HMO approach and, after considerable analysis, determined that the company would be exposed to an unacceptable level of financial risk and that too much staff time would be required to develop a program with the necessary components to be successful. Company O and Company K continued to express interest. Company O made no concrete progress on a feasibility study, having difficulty finding a location with a large number of retirees and HMOs available and also obtaining utilization data from its insurer. Company K made substantial progress, choosing locations and starting preliminary discussions with insurers. Details of the activities and outcomes in working with K and O are included in the company descriptions which follow.

HMOs as a New Venture

The project staff used two approaches to stimulate corporate support for ADS growth and development. The first was to encourage corporations as employers to adopt one or more of the various methods of involvement open to major employers within a given community. This would include using their purchasing power to encourage physicians and hospitals to form alternative plans, making financial or in-kind contributions to developing plans, membership on HMO boards, or direct sponsorship either in collaboration with others or as a solo effort. A summary of our efforts in this area may be found within the individual company summaries in Section III.C.

The second approach, which was introduced in Phase 2, was to explore the feasibility of HMO sponsorship as a corporate for-profit venture. The primary emphasis in this type of investigation was to evaluate the return on investment potential of HMOs and the attributes of these corporations which would contribute to making them a successful competitor in the health care industry. This section describes the nature of our activities under the new ventures approach.

The notion of HMO development as a venture possibility was first raised in our initial kick-off discussions with each of the companies. At that point we were meeting with executives and staff from the benefits departments. While their responses were of interest, we realized that the new ventures or strategic planning

executives would be the appropriate persons to conduct an evaluation of the concept. From these meetings, however, it was clear that two of the companies (X and K) were highly unlikely candidates since profits were depressed or non-existent for them at the time and, further, they were heavy industry companies with no expertise which would readily translate to health care delivery. The other three appeared to be more promising candidates as their companies were doing well and two of them had extensive capabilities in computerized information systems and expertise in service-type industries.

The project staff drafted formal letters to individuals within each company. In three cases, we were able to identify the appropriate ventures personnel to address with the assistance and encouragement of our benefits contacts within the companies. In two cases, the letters went to the Director of Employee Benefits with a request that they put us in touch with the ventures department. (See Figure 2 for a depiction of the level of our contacts and the responses.) Each letter contained an overview of why we believed HMO development to have attractive investment potential and was tailored to the interests and capabilities of that company. The letter concluded with a request for a meeting at which Dr. Ellwood and John Anderson would present the findings from a recently completed feasibility analysis for a national HMO firm, address general issues, and answer questions raised by company executives. A sample letter is included in the Appendix for Year IV.

Only one of the companies (Company P) expressed interest in a meeting. Of the two other likely prospects, M considered the idea at an appropriate level within the company (executive vice president), but decided that the company should not diversify to that extent and that there were ample opportunities for new ventures within the telecommunication industry; X's consideration of it went no farther than the benefits department. The company descriptions for M and X describe the process and outcomes in more detail.

Dr. Ellwood and Mr. Anderson met with the director and staff of Corporate New Ventures for Company P. A summary of that meeting is included in the Company P description. At the conclusion of the discussion, Company P officials indicated that further consideration of HMO development as a corporate venture was not appropriate -- it would be too unrelated to their traditional lines of business and there were numerous other opportunities which were more attractive and occupied the firm's scarce management resources.

Figure 2

SUMMARY OF CORPORATE NEW VENTURES EXPLORATION

Company	Initial Discussions	Formal Letter To	Response
P	Director, Benefits, & Staff	Director, Corporate New Ventures	Met with new ventures and bio-medical executives. Outcome: no interest, too unrelated to company's line of business.
M	Director, Corp. Medical Director, Benefits	Executive Vice President	Discussions within the company, Dir. of Corp. Medical notified us that M will confine new ventures to telecommunications.
O	V.P., Benefits Administration & Staff	V.P., Strategy & Corp. Planning	No interest.
X	Director, Benefits, & Staff	Director, Benefits	The request for discussions never reached ventures division.
K	Director, Benefits, & Staff	Director, Benefits	The request for discussions never reached ventures division.

Thus none of the five companies were willing to pursue the idea of HMO sponsorship as a for-profit venture. The project team was disappointed, but not very surprised. The only firms to have entered the HMO field as a venture proposition thus far have been health care-related firms: insurers, former health care managers, or HMO plans themselves. The only instances in which corporations whose traditional line of business is not related to health care delivery have directly sponsored HMOs is as an employer seeking improved medical care for employees in a major location (e.g., R. J. Reynolds, Deere & Company, Caterpillar, and Ford).

Company K

Description of the Company:

Company K was a target company during the second year of Phase 1. (A more complete description of the company may be found in Section II.) It is a very large, labor intensive manufacturing company headquartered in a major midwestern city. The company has over 20 locations with 20,000 or more employees. A primary reason for continuing to work with them during Phase 2 of the project was the recognition that, because of its size, even small changes in policy could have a considerable impact on both the company and on the community.

Health care policies in Company K are a joint concern of the medical department, the employee benefits department, and the finance department. Coordination among the three departments is apparently good, but the decision-making process is complex. Further, the company is highly unionized and the unions play a major role in influencing health benefits policies. Company K administers all HMO offerings from the headquarters offices. In 1981 it offered a total of 80 HMOs to non-unionized personnel while just over 40 were approved by the union for hourly workers.

Summary of Activities:

1. Communities

In an initial Phase 2 meeting, Company K expressed a strong interest in continuing its involvement with the Dayton HMO Task Force (initiated during Year II of the project through the efforts of the InterStudy project team). In addition, the employee benefits director and staff wanted to investigate the possibility of focusing on Atlanta, Kansas City, Fredrickburg, or Los Angeles. The project team supplied Company K with community data profiles on each city which described trends in local health care resources, utilization and cost, as well as information on ADS development and performance. Company K staff considered establishing a series of in-house training seminars for field representatives on the topic of effective membership on employer health care coalitions. InterStudy staff briefed

headquarters' staff on the activities of the Dayton coalition and suggested that the company use its experience there as a case study for the seminars. By mid-Year III, however, a sharp decline in profits led to budget cuts for corporate departments, and the seminar idea was indefinitely cancelled. It was further decided that Company K would encourage field personnel to participate in local coalitions as they formed, but would not initiate their formation. For the remainder of the project, InterStudy provided staff support to the existing coalition efforts in Dayton and later Oakland.

A Company K division personnel director was an active member of the Dayton coalition, led by the CEO of a local corporation. In Year III the project team provided extensive support for the coalition, developing an HMO evaluation protocol for the group and assisting them in conducting the evaluation. Project staff further assisted as the coalition sought to boost enrollments in the two new HMOs through a community-wide educational effort and assistance to companies and unions in the initial HMO offerings to employees. Year IV activities included revision of the protocol and a second evaluation period. Project staff aided members of the coalition in drafting a case study on the coalition's success in generating corporate and labor support for HMOs. InterStudy and the Dayton coalition are offering the report as a guide for other companies and coalitions. The project team contacted the Company K representative of the Oakland employer coalition which was formed late in the project period. Staff sent relevant materials to assist the coalition as they began formulating an action plan, and Dr. Paul Ellwood held an informal discussion with the group in the spring of 1982.

2. Internal Cost Containment

The project staff aided Company K in two major areas: monitoring newly developed HMOs where Company K has a concentration of employees and evaluating a major risk insurance plan proposed to the company by a state medical group. The HMO monitoring included an assessment of several HMOs at Company K's request and suggestions for other new plans the company should consider.

Project staff continued to urge a policy of equal contributions to all health plans, but without success. Not unlike many other corporations whose indemnity insurance premiums exceed HMO premiums, Company K pays for the indemnity coverage but offers no rebate to HMO enrollees. Union opposition to equalizing the contribution is a significant factor, but the company could alter its policy for salaried workers regardless of the barriers for hourly workers.

3. Retiree Demonstration

Among the five target corporations, Company K demonstrated the strongest interest in this area. This is not surprising since it is a mature, labor-intensive company that purchases supplemental health benefits for thousands of retirees throughout the United States. Company K authorized the project staff to collect information on three potential locations for HMO/retiree demonstrations and to contact major insurance companies to explore their interest in designing a non-HMO alternative to the present Medicare/Blue Cross coverage for retirees. In two preliminary meetings in October and February of Year IV, the project staff met with headquarters' staff for background discussions on the issues and options. Project staff arranged for a third meeting in June of three interested insurers, two HMOs, HCFA, and Company K staff to discuss ideas for designing an alternative to the present coverage. Although this meeting was held just prior to the conclusion of the project, it is clear that there is considerable enthusiasm for such a demonstration and that implementation is likely to occur. One of the HMOs has a demonstration contract with HCFA, and it is virtually certain that Company K retirees will be offered the opportunity to join the plan by next April. The likelihood of an insurance experiment is less certain, since the insurers would be asked to assume at least a portion of the risk for a fee-for-service alternative (something they have not done for an employed population, let alone an over-65 population). Of the ideas discussed, a preferred provider organization (PPO) and/or stringent utilization review appeared to be the most promising approaches. Company K remains interested in pursuing an insurance demonstration and plans to continue discussions with two of the insurance participants.

4. HMO Sponsorship

Company K expressed no interest in sponsoring the development of HMOs as a for-profit investor or as a purchaser of health benefits. The only time the company has invested any significant staff time or money in an HMO occurred in the company's home city and that was through the strong leadership of another major headquartered company and the union each is affiliated with. An attempt to reach the new ventures department through our project contact failed, apparently because the employee benefits staff believed that the company's declining financial performance and its traditional reluctance to enter non-related industries made further inquiries impractical.

Analysis:

As discussed in the Phase 1 case summary, the drawbacks in working with Company K included fragmentation of the responsibility for setting health benefits policies and the inherent problem of working toward change in an organization of this magnitude, especially when the union is a strong and conservative force.

The failure to establish activities in a community in addition to Dayton may be the result of several factors: the company entered unexpected and time consuming union negotiations in the last year of the project, departmental budget cuts limited the activities of corporate staff, and/or the inability of the project staff to stimulate sufficient interest. Company K headquarters' staff has been willing to support field personnel once a coalition is formed, but has not encouraged staff in the field to initiate action. It is apparent in recent discussions, however, that there is renewed interest within Company K in establishing a single site demonstration project where several innovations can be tested, including policies that would aid ADS growth (e.g., equal contributions, more effective education for multiple choice offerings, PPO contracts, etc.).

Critical Factors:

Positive:

1) A new director of employee benefits who seems to be more positive toward HMOs and other alternatives.

2) Increased willingness on the part of the union to consider changes that would slow health benefit cost increases.

3) High insurance costs and large concentrations of employees make it worth the company's efforts to promote HMO choices.

Negative:

1) Cumbersome organizational structure and understaffing inhibit innovations.

2) Significant policy changes must be negotiated with the union.

3) Reluctance to "stir the waters" in local communities.

Company M

Description of the Company:

As described in Phase 1, Company M is a large decentralized utility company in the midst of a federally mandated corporate reorganization process. During the course of Years III and IV, Company M reorganized to profit and non-profit entities as well as divesting the parent company from each of its regional subsidiaries. During the course of the project team's work with Company M, we have maintained contact with both the parent company and the now divested subsidiary located in Philadelphia, Pennsylvania.

Our contact on health care issues has remained the employee benefits manager with each organization. As mentioned previously, Company M's industry is heavily unionized and this fact significantly influences benefit design and negotiation. Company M's interest in pursuing the activity of Years III and IV was several-fold: a) the corporate medical director recently developed a utilization monitoring system and a study of employee absenteeism and was interested in applying the systems at other company sites; b) Company M had developed an HMO Guide for local sites and was interested in continued refinement; c) Company M was eager to develop greater local involvement through coalitions, HMO boards, hospital boards, and health planning boards.

Summary of Activities:

1. Communities

Company M identified Philadelphia, Pennsylvania as its primary target community (Kansas City, Missouri was a secondary target). Philadelphia was selected for several reasons: 1) a large number of employees were located in the area; 2) the employee benefits department of Company M's Philadelphia subsidiary was managed by a person who was active on various business coalitions and expressed interest in cost containment; and 3) the Philadelphia area's ADS was in need of support and further competition.

Company M was already a member of the Penjerdel Coalition, an organization that had already focused on utilization data and benefit design and was showing increasing support for HMO development. Company M, through its own hospital utilization management system, was able to provide specific cost and utilization figures for its own Philadelphia employees. Project staff, in the first part of Year III, provided background research on existing ADSs and local corporate activity in health care issues. From this research, and a study by the Office of Health Maintenance Organizations, came the assessment that four of the five HMOs in Philadelphia were not showing significant enrollment growth. The fundamental problems appeared to be: contracts with expensive hospitals, inaccessible clinics, and poor marketing. In response to this evidence, project staff arranged several meetings with the Company M subsidiary, Company M's union representative, Philadelphia Chamber of Commerce, Group Health Association of America, and three of the five local HMOs. Though fundamentally an information and education effort, Company M and other Philadelphia companies expressed a desire to support HMOs and competition and to be receptive to improved marketing efforts by the HMOs. Company M and its Philadelphia subsidiary both expressed less interest in coalition support (they were already very active) and great interest in our support of their efforts to strengthen existing HMOs (through capital or management) or introduce new ADSs. Company M's subsidiary especially expressed interest in PPO development in the Philadelphia area.

2. Internal Cost Containment

Company M did not seek a great deal of assistance from the project team in the area of internal cost containment. The company had already developed a fairly sophisticated computerized system of monitoring hospital utilization for employees. The system was operational in 1978 and is based on data output from the Blue Cross claims processing system. Company M, as of 1979, was able to look at utilization and cost for about 10% of its employees and dependents and is presently moving to implement a company-wide system with the capability of addressing issues of planning, budgeting, negotiating, and monitoring. Company M has also been looking at comparative absenteeism of HMO and non-HMO members at four company sites. Throughout Years III and IV, project staff continued to encourage Company M in the areas of benefit design, data collection and analysis, design of proper incentives for employees, and efforts to better communicate to and educate employees on issues of health cost and health promotion.

3. Retiree Demonstration

Company M did not express interest in pursuing the Medicare demonstration for retired employees.

4. HMO Sponsorship

Company M, and in particular the manager of employee benefits at the Philadelphia subsidiary, was very interested in establishing a preferred provider arrangement for Company M employees in the Philadelphia area. Company M was less interested in HMO sponsorship, stating they would concentrate on supporting existing Philadelphia HMOs through coalition efforts.

Discussions about PPO feasibility in Philadelphia began early in Year III. Project staff worked directly with the Philadelphia benefits manager, preparing materials that defined the PPO concept and interpreted the experience of several newly established PPOs around the country (Denver, San Francisco, Los Angeles, and others). Early in Year IV, project staff began meeting in Philadelphia with the benefits manager to lay out the framework of a PPO variation proposed by the manager. Company M's manager proposed an arrangement that would offer Company M's employees the option and incentive to select from a designated panel of HMO specialists, when such referral is recommended by a non-participating primary care physician. The basic components of this system would include:

- An incentive for employees to choose this option -- waiver of traditional copayments or deductibles.
- A telephone network at the company to assist employees, or their primary care physicians, in obtaining referrals to the designated specialty panel.
- A negotiated reimbursement schedule for HMO specialists similar to that now offered by the HMOs.

Such an arrangement offers several advantages for those involved. HMOs and their specialists would presumably realize increased patient volume and may attract new HMO enrollees. Employees would benefit from waived copayments and/or improved benefits. Company M's subsidiary would benefit by directing employees to more cost-conscious providers and also by creating a dialogue with their employees that might result in better consumer education regarding cost control.

InterStudy staff has devoted considerable time to defining the details of this proposal and assessing its workability. This effort is outlined in Appendix E, which includes an internal InterStudy memo and two letters of correspondence. As noted in the memo, our major concerns are these:

- The proposal will require a great deal of responsibility and cooperation from primary care physicians and employees to make use of the panel of specialists. There are no real incentives for primary care physicians to cooperate.
- The proposal's impact on cost containment and competition would be greater if HMO primary care physicians were also included.
- Because most specialists are contracted by HMOs, not salaried, it may be unnecessary to direct a portion of the total reimbursement back to the HMO organization (5% of total charges in the AT&T proposal). This 5% could instead be retained by AT&T or be applied to administrative costs and improved employee benefits.

In March 1982, project staff arranged a series of meetings with five Philadelphia HMOs, Company M's manager, and Dr. Ellwood. During these meetings, Company M's proposal was defined and presented to the HMOs for consideration. Interest was shown by three of the five and further negotiations were conducted over the next two months by Company M's manager and project staff. A significant hurdle was overcome in June 1982, when the manager secured a tentative agreement from Company M's carrier to reimburse at its usual rate directly to the HMO for services rendered by a PPO-participating specialist.

At present, the PPO proposal is in its completed form and three Philadelphia HMOs are reaching a final decision on whether to participate. Company M has instituted the proposed telephone network to educate employees about their range of health benefits and to provide them a list of participating HMO specialists. Company M has secured a tentative agreement on reimbursement mechanisms between the Company's carrier and potential HMO participants.

The project team was able to reach the appropriate level within the company for an exploration of HMO development as a corporate venture. Dr. Ellwood had prior contact with the executive vice president of Company M and began early discussions with him regarding the concept. The discussions were followed by a formal letter similar to that sent to all the corporations, but emphasizing the potential synergy

between Company M's existing expertise and the capabilities needed to be a successful HMO competitor. The vice president held discussions with the director of the corporate medical department and concluded that the company had more than ample venture opportunities in more closely related fields and that further exploration into health care delivery did not fit into their corporate strategy.

Analysis:

A major source of frustration when dealing with Company M is the vast size of the Company and the degree of decentralization and fragmentation in its organization. Though our efforts caught the attention of fairly prominent figures in the Company, it was difficult to formulate a broad ranging plan of action, gain wide company consensus, and implement the planned action. Without doubt, Company M was concerned as a whole and very active on various issues and in various sites -- but had difficulty coordinating around a comprehensive strategy.

Company M demonstrated a positive attitude toward HMOs, but the facility with which HMOs were offered varied widely across the country and overall penetration in the company was not great (roughly 5%). Company M was supportive of HMOs in coalition activities, but no tangible evidence of the Company's positive impact on HMO growth is evident.

Definite progress was possible when the effort focused on a single site (Philadelphia) and was coordinated through a single Company M officer (benefits manager). However, this approach does not correct the problem of decentralization and, in fact, furthers the problem of Company M's fragmented approach to solving their health care cost situation.

Critical Factors:

Positive:

1) Positive stance on HMOs and ADSs generally.

2) Initiative in developing a computerized system of monitoring health care utilization and cost.

Positive: (cont'd.)

3) Initiative in studying HMO impact on employees (absenteeism study).

4) Active participation on coalitions -- evidence of willingness to try an "experiment" on a local level (PPO implementation in Philadelphia).

Negative:

1) Far too decentralized and fragmented to establish a broad ranging and coordinated strategy for managing health care costs.

2) Concurrent corporate reorganization process was a distracting force during this project.

Company O

Description of the Company:

Project staff had worked with Coalition O, of which this company was a member, during Phase 1 of the project. During this time, it became evident that the company was interested in pursuing follow-up activities in Phase 2.

The company is a very large manufacturing company headquartered in a major industrial city in the East. Total employment is over 100,000, spread over about 35 locations; the average workforce at any given location ranges from a low of 500 to a high of 20,000. Two major reasons for continuing work with them during Phase 2 were the chance to work with a leader in a major industry and the company's expressed interest in health care cost containment.

Health care policies in Company O are handled through the Employee Benefits Department which reports to the Vice President of Administration. Decision-making is highly centralized, using staff at the company headquarters to determine HMO offerings, cost containment activities in local communities, etc. Further, the company is highly unionized and must work within the framework specified by union contracts. Since only about 20% of the total workforce is salaried, the union settlements are very influential in total corporate policies. The company is very cautious in its approach to offering HMOs; they are not convinced that HMO development will help control health care costs and they are also unconvinced that a methodology can document an impact on costs.

Summary of Activities

1. Communities

During the initial planning meeting, four communities were designated as being of special interest: Lorain, Ohio; Birmingham, Alabama; Pittsburgh, Pennsylvania; and Gary, Indiana. During later follow-up, the Gary location (including southern Chicago) was chosen as the target community for this project.

Work commenced for the Gary area with a three-day on-site investigation of the area. Contacts were made with the local HMOs and other sources of information; including DHHS, the Midwest Business Group on Health, and the National Executive Service Corp. Of the seven HMOs in the area, two were particularly interested in serving the Gary area, even to the extent of adding branch offices if local employers expressed support.

Based on the results of this trip, recommendations were made to Company O to:

1. Expand HMO offerings in Gary.
2. Improve HMO offering materials and procedures.
3. Consider establishing an employer coalition in Gary.

Company O did agree to offer one more HMO and to have project staff work on improved offering materials. Jan Malcolm and Ann Perkins of InterStudy worked closely with Company O during the summer of 1981 to develop more streamlined offering materials. Many of our suggestions and revised products were adopted by Company O, including:

- an easy-to-read cover letter more hospitable to HMOs;
- revised benefit comparison sheets using standard language and describing the two-part company plan as an integrated whole;
- changes in sign-up procedures so an HMO is not more difficult to choose than an indemnity plan; and
- methods of educating employees about their choices.

The new materials and suggestions developed by the project team will be used in other company locations as well.

HMO enrollment in Gary increased 28% from the previous year, although total penetration is still low (about 2%). Company O also offered a new HMO to Pittsburgh union members. While penetration was low for the union, it doubled among non-union employees.

In addition to our work in Gary, Walter McClure, InterStudy, spoke at a meeting of major employers, including the benefits director of Company O, in Pittsburgh in April 1981. This meeting was sponsored by the Allegheny Conference, a prominent civic group. A meeting was also arranged with the director of health and welfare for the union, who had some reservations about fair market choice, expecting it to mean a change from bargaining for benefits to bargaining for dollars.

2. Internal Cost Containment

Company O requested that InterStudy match existing HMOs with plant sites which currently had over 450 employees in order to determine where multiple choice offerings might be considered. A report was developed for 33 sites listing HMOs available, background information, and enrollment and utilization data. Project staff continued to encourage the company to expand multiple choice offerings where possible since the union has agreed to the concept as long as union leaders approve each HMO offered.

Company O, working with its insurer, developed some cost and utilization indices for 11 areas. Interest was expressed in expanding this monitoring system, perhaps in conjunction with other corporations. InterStudy provided the initial liaison with Company M who had developed an in-house monitoring system. The strong interest expressed by these and other companies led to InterStudy sponsoring the data conference described previously.

A separate cost containment issue is how to deal with the costs of medical education and research at academic medical centers. During the fifth quarter of this project, InterStudy was requested to outline major issues facing academic medical centers, preparatory to a speech to be given by a senior executive of Company O, to the Association of Academic Health Centers. Four issues targeted by Dr. Ellwood were:

- Medical education and research must be financed in an equitable manner.
- Academic health centers should become models for the efficient delivery of medical care.
- Academic health centers should lead in health delivery research as well as clinical research.
- Academic health centers must realize that business is serious about controlling health costs.

3. Retiree Demonstration

Company O was one of the companies eager to learn more about how a Medicare demonstration project might be developed. After receiving our initial explanatory papers (described previously), a meeting was arranged for late October to discuss whether and how to proceed. Ann Perkins and Jerry Meier of InterStudy were present at the meeting, along with four representatives of Company O. The company was interested for two major reasons: 1) to provide quality care at a lower cost and 2) to demonstrate to government and industry better ways to provide health care.

The major emphasis was on an HMO approach. However, the areas with the largest numbers of retirees do not have HMOs of any significant size. Further, Company O remains unconvinced that HMOs really save money. The company agreed to start studying ways in which the project might be developed and also to get information from its insurer on the relative costs of retiree coverage in various locations.

At about the same time, the University of Pittsburgh Medical School started to analyze the pros and cons of developing a prepaid program. One possible option would be to start such a program by serving the local Medicare-eligible retirees of Company O. Company O agreed to participate in such a project when it was developed, but declined to take the lead in the feasibility process. Further details of the University's plan may be found in the following section.

Numerous attempts were made by project staff to move the feasibility study process forward. Also, the company continued to express interest in the project. However, few concrete steps were taken. There were great difficulties getting data from the insurer; therefore, it was difficult to consider specific locations. Further, corporate staff appeared to have a full workload already without embarking on yet another project.

4. HMO Sponsorship

During the seventh quarter of the project, InterStudy was approached by the University of Pittsburgh Medical School regarding a prepaid capitation project. One option noted above would be to start this project by offering care to Company O's Pittsburgh area retirees. The strong interest and support expressed by Company O and other businesses encouraged the University to investigate further.

InterStudy staff, including Dr. Paul Ellwood, met with representatives of the Medical School in November 1981 to discuss the advantages and disadvantages of a prepaid capitation project. There was strong interest expressed by several high-level faculty members. The University was encouraged to proceed, both by the project team and a number of local corporations, including Company O. After this meeting, InterStudy continued to provide support for the University as it explored the program further, even offering to provide some staff time to help with a feasibility study. As of the close of this project, the University was proceeding with a feasibility study. The outcome is not yet known.

The project team also worked directly with Company O to encourage it to consider ADS development. The director of employee benefits urged the project team to contact the vice president of strategic and corporate planning on the new ventures concept. The vice president expressed no interest in pursuing the idea of HMO development, so no further attempts were made. Poor financial performance by the company over the last several years was undoubtedly a factor as was the lack of transferability of current expertise (heavy industry) to a totally unrelated business.

Analysis:

Company O expressed interest in a number of the projects and activities undertaken during Phase 2. Community work, especially in Gary, had a successful outcome of more HMOs being offered and increased HMO penetration achieved. Project staff did all the background work and prepared revised offering materials. Company O then simply had to review the work, make any changes it wished, and proceed to implementation. In essence, the availability of extra manpower led to the completion of necessary work and the outcomes noted above.

Project staff played more of a consulting role regarding cost containment activities. Our efforts were focused on educating the company on what options were possible and how they might proceed. Company O was engaged in a major data collection project with Blue Cross/Blue Shield. However, once the data showed certain areas to be high cost or have utilization substantially different from the norm, the company was reluctant to undertake remedial action. The

exception was in Birmingham where Company O used its utilization and cost data to secure the commitment of physicians to voluntary action to reduce hospitalizations. It did not choose to use its market power to effect change. Nor did it push its insurer to do so. The company basically seemed to be afraid to "rock the boat". Possible reasons for this position include: lack of strong executive commitment, presence of a strong conservative union, and fear of alienating the medical community.

Interest was expressed in developing a retiree demonstration project. However, the sheer magnitude of work required, potential cost, and lack of alternative plans to provide the benefits resulted in inactivity being the principal activity. The company stated it had no time or resources to consider developing an ADS; all new ventures would be related to its basic industries.

To summarize, the lack of commitment to a specific cost containment strategy and the lack of adequate staff time prevent Company O from taking any major steps at this time. Further, the presence of a very strong and conservative union makes change even more difficult and slow. However, the potential for significant activities is present in the centralized policymaking and administration functions; the company must decide to commit adequate resources and manpower to turn this potential into progress.

Critical Factors:

Positive:

1) Increased corporate interest in holding the line on <u>all</u> operating costs.

2) Increased willingness of the union to consider multiple choice, utilization review, and other cost containment activities.

3) Availability of cost and utilization data to determine problem areas and devise appropriate solutions.

4) Centralized policymaking for uniform decisions.

Negative:

1) Lack of strong corporate commitment to multiple choice and HMOs.

2) Lack of staff time to follow through on specific projects.

3) Very powerful union skeptical of cost containment activities and in an essentially adversarial relationship with company.

4) Reluctance to intervene with providers to deal with problems.

Company P

Description of the Company:

Project staff worked with Company P during the second year of Phase 1 as well as into the Phase 2 continuation. (A more complete description of the company may be found in Section II, Phase 1, Company Case Summaries.) Company P is a leader in the high technology office equipment industry. The company is not unionized, has a mobile labor force and locations throughout the country. Responsibility for health benefits policy and administration is centralized. In 1979, a central HMO department was created to handle all HMO evaluation and administration. The office is within the employee benefits department which reports to personnel.

The company is acknowledged as "pro-HMO", primarily because of the sophistication and positive nature of its HMO offering materials and its policy of offering all federally qualified and state certified HMOs. HMO enrollment penetrations, while growing, remain under 10% of the workforce. There may be several reasons for this, including a lack of HMO plans in some of their major locations, a corporate policy prohibiting direct HMO marketing on company property or during working hours, and a relatively low company plan premium which requires employees to contribute to the HMO premiums. Company P is characterized by a reluctance to be the dominant force in any community in which it is the major employer, but at the same time encourages its local employee benefits personnel to participate in joint employer health care coalitions.

Summary of Activities:

1. Communities

In initial meetings, Company P staff expressed an interest in support for the existing coalition in Fairfield/Westchester and a newly forming group in Endicott, New York. Secondary targets identified were Boulder and Boca Ratan. Assistance provided by the project staff included ongoing consultation to the FWBGH (Fairfield/Westchester coalition) related to strengthening the local group practice HMO and a developing IPA. This included discussions on capital formation and suggestions

for enhancing management expertise within the plans. Company P representatives on the two coalitions (FWBGH and Endicott) participated in InterStudy's coalition seminar at the end of Year III. During Year IV, project staff urged the Endicott group to take an active role in HMO formation, but failed to stimulate a commitment to that goal.* The coalition spent much of Year IV in general organizing efforts and data collection and does not appear to have an action program in place at the time of this report. Company P headquarters staff, likewise, has urged that the coalition encourage HMO formation and make use of the InterStudy project team, and is disappointed thus far with the apparent lack of progress.

Company P requested assistance in examining the potential for future HMO offerings in Boulder and Boca Ratan. There currently are no HMOs in the vicinity of those plant locations. Project staff held discussions with a Denver network model HMO on Company P's behalf, urging it to consider adding a group practice in Boulder to its network. In spite of these efforts, the Boulder group voted to postpone consideration, perhaps because the network is new and relatively untested. There was no apparent provider interest in Boca Ratan. Company P did not wish to initiate new coalitions in these communities or become directly involved in HMO development.

2. Internal Cost Containment

Because Company P's corporate policies are already quite progressive and supportive of HMOs, project staff decided to concentrate on two major areas: (1) examination of company data in part to determine whether their HMO contributions are equitable and thus conducive to fair market choice and (2) support for further sophistication of the company's health care monitoring activities. Because of its resources and capabilities as a major computer company, project staff believed that such cost and utilization studies could become models for other companies.

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*HMO development had been a controversial issue in that community over the last 5-6 years, and several feasibility projects have resulted in "no go" decisions.

The company data base contains relatively detailed information regarding average rates of use and cost of health services per employee for 16 major locations. The company asked that InterStudy review their experience over the past several years to identify areas of excessive cost and to suggest cost containment approaches it might use for those locations. In addition, HMO contribution rates were to be analyzed relative to local costs. Project staff findings indicated that Company P costs were highly variable across the country and that nine of its locations were particularly high and should be targeted for action. Our analysis of HMO contributions demonstrated the extent to which its policy of averaging costs by state and then again by regions masks actual cost differences for cities within those regions. The project staff proposed that Company P base HMO contributions on actual indemnity costs for the 30 standard metropolitan areas in which it has more than 1,000 employees. For all other locations (less than 1,000 employees) the current averaging technique would continue to be appropriate.

Other recommendations in the report included a proposed approach for estimating the age and sex of dependents and adjusting location-specific utilization and cost data so that comparisons could be made across Company P locations, and an approach for targeting communities for cost containment activities. The latter included the development of a set of criteria to identify problem locations, suggestions for identifying the factors that contribute to high costs, and a proposed program of action for one such location.

3. Retiree Demonstration

Company P was favorable to the idea of a retiree demonstration, but decided early in Year IV that further exploration was impractical. Because this company is relatively young compared to the other four target companies, Company P has fewer retirees at the present time and thus less reason for immediate concern. However, it recognizes that retiree benefits will become an increasingly large component of its benefit dollars and continues to follow progress in this area with interest. Company P declined to pursue a retiree demonstration at this time, primarily because there are no HMOs in locations where they have large concentrations of employees, in particular, central New York state. Company P felt HMOs are the logical sponsors of such an experiment and was not interested in pursuing an insurance alternative.

4. HMO Sponsorship

Company P was regarded as one of the companies most likely to be interested in HMO sponsorship -- not only as an employer supportive of HMOs, but as a highly capitalized for-profit firm interested in new venture possibilities. Consequently, exploration proceeded on two fronts; first with the employee benefits department and later with new ventures personnel. Work with the employee benefits department was referred to in the "communities" section. In only one case during the project period did the benefits staff become actively involved in efforts to "shore up" an HMO; perhaps not coincidentally, that occurred in the headquarters' locale. While headquarters' staff would like to see stronger encouragement of HMOs, they seem reluctant to become involved in the field locations, preferring to rely instead upon field representatives and other employers in the area to set the course of action.

In Year IV, Dr. Ellwood and other project staff met with the Director of Corporate New Ventures and two members of his staff as well as a member of the Biomedical Systems Division. During the discussion, Dr. Ellwood presented an analysis of the current state of health care delivery and projected changes which would open opportunities for new types of health care firms in the future. He pointed out the strengths that Company P would bring to this industry; management expertise in the critically important areas of marketing, research, and computerized management information systems. He further described the options for entering the field, and elaborated on one approach that might be of particular interest to Company P: affiliation with a newly developed national firm. The hypothetical prospectus he presented included a business plan and financial projections over a ten-year time frame for such a firm. While the representative from the Biomedical Systems Division was highly receptive to the analysis of future directions of the industry, the new ventures staff expressed no continuing interest in the ideas proposed. The stated reasons for rejecting the notions were as follows:

- they were skeptical of the concept of synergy between Company P's existing capabilities and the health care delivery business, and
- they preferred to pursue opportunities in fields more directly related to their traditional lines of business.

Analysis:

This company is one of the more outspoken proponents of HMOs in this country. Members of the company's benefits and personnel departments are active members of national employer associations, making presentations, contributing to articles and studies, and accepting leadership positions. In addition to speaking out in favor of HMOs, Company P representatives also urge the development of employer coalitions, monitoring of health care costs and utilization, and employer involvement in local health planning. It stops short, however, of direct sponsorship of HMOs*, campaigns or demonstrations to improve HMO enrollment penetration in selected sites, or public presentations of its data analyses.

It seems clear that the adoption in 1979 of a formal corporate health benefits policy provides Company P staff with a clear framework and allows them to speak with clarity and consistency. That it has not led to more direct involvement in boosting HMO development and market penetration or the initiation of local action coalitions seems related to the company's desire to avoid using its "big stick" to influence the behavior of its own employees or health providers in its major locations. If Company P employees wish to choose alternative health plans, they have a broad array of plans to consider. If field staff wish to join an employer coalition, they are encouraged to do so. If health providers want to develop ADSs, they likewise are given encouragement. But, Company P apparently will not use its vast resources to tilt the direction the health system is moving unless it receives a clear indication that its help is wanted.

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*It did consider joining with some other local employers to put a small amount of seed money into a developing IPA and is likely to consider that level of support appropriate in the future.

Critical Factors:

Positive:

1) Company has made a commitment of time and funds to internal and external activities supportive of HMOs.

2) Company visibility and leadership has been an important factor in stimulating the support of other employers for HMOs and multiple choice.

Negative:

1) Company reluctance to allow HMOs to market directly to employees.

2) Company preference for a low profile approach in major employment communities.

3) Under commitment of staff resources for general cost containment activity, including monitoring of costs and utilization. That responsibility lies with one person at a relatively low level in the department.

Company X

Description of the Company:

Company X was selected as the fifth company for Phase 2 activities following a series of discussions beginning in August 1980 and involving Dr. Ellwood, project staff, and the manager of Company X's employee benefits department. Company X is a major refining and processing company headquartered in New York City with employees at multiple sites in the United States and abroad. Company X is not heavily unionized and is presently self-insured and has contracted with two claims administrators for medical and dental coverage. Organizationally, health care issues are addressed by the Employee Relations Department, which is comprised of Benefit Plan Administration, Corporate Medical, Labor Relations, and Program Evaluation and Analysis.

Company X's Employee Benefits Department has shown interest in efficient management of health benefits and cost for several years prior to our contact. Within Benefit Plan Administration, Company X has already identified an in-house consultant for health care cost issues. In 1975, Company X addressed the issue of HMOs and at that time took a negative stance toward them. Consequently, HMOs realize a minimal penetration at each of Company X's sites due primarily to lack of active support by the company.

Company X and the project team found several reasons to pursue joint project activities. Company X was concerned about the rising health care costs in several of its sites: Beaumont, Texas; Denver; Philadelphia; Chicago; and the Fairfield/Westchester area. Company X was also interested in developing an efficient means of gathering and analyzing data on health care costs and utilization. Company X was willing to review its HMO policy -- to consider the impact of its negative stance. The company was also concerned about improving the health education and lifestyle of its employees.

The project team's work with Company X officially began in December of 1980.

Summary of Activities:

1. Communities

Company X determined that its primary target community for Phase 2 activities would be Beaumont, Texas (with secondary targets designated to be Chicago and Fairfax, Virginia). Beaumont was an area of particularly high health care cost for Company X, and Company X had already hired a consultant to analyze the Beaumont situation. Company X also had previously explored the possibility of a coalition effort with area industry in the Beaumont/Port Arthur/Orange area, and was encouraged by InterStudy's assistance.

Beginning in January of 1981, project staff worked closely with the headquarter staff of the Company X and Company S benefits departments to aid in the implementation of the Beaumont coalition. Project staff provided community data profiles of Beaumont, outlining important trends in the utilization and cost of local health care resources, as well as an assessment of local ADS development (a copy of the profile is found in Appendix C, and is an example of the type of profile provided each of the companies). The two companies first met with project staff in New York City on February 5, 1981 to discuss Phase 2 action steps. This was followed by a meeting of these same parties in Beaumont on March 27, 1981 to further discuss the local health care situation and to begin formulating a community-based action program. Interest was high and discussion focused on the scope of the proposed coalition's activities, how to establish a consensus on action, how to begin collecting appropriate data, how to staff and fund the coalition, and whether to involve providers at the outset. In May of 1981, InterStudy provided assistance through a seminar on Corporate Health Care Monitoring.

Companies X and S continued to show interest in the successful organization of a coalition in Beaumont.

The first meeting of eight major Beaumont employers occurred June 12, 1981. The group designated Company X's local employee relations manager as chairperson. The group's discussion focused on several issues: Companies X and S described their experiences with rising health care cost in the Beaumont area; they each

explained their purpose for participating in the coalition effort; and InterStudy staff presented an overview of current business coalition approaches around the country. There were unanimous agreement to proceed with definition and solution of problems. The project staff began assisting the coalition's effort toward definition by preparing an analysis of data on the Beaumont area -- SMSA demographics, hospital costs and financial information, physician distribution, and data on utilization (Appendix D). Though the data analysis convinced local Company X staff of some of the sources of rising health costs in Beaumont, it did not appear to help the coalition define or agree on action steps and there was growing evidence of inaction by the coalition. Staff of Company X's headquarters was still very much interested in seeing some coalition results, and this attitude prompted a meeting in New York City between the benefits staff and project staff (October 1981). The goal of this meeting was to encourage headquarter staff to assume greater direct responsibility for the coalition's success. Several difficult issues were raised during this discussion: a) the difficult task of clearly communicating headquarter's concern over rising costs to local managers; b) the resistance local managers show toward agitating their local health care community; and c) the fact that issues of health care delivery and finance are "new territory" for them all. Project staff continued to play a supportive role and to provide data, analysis, and recommendations when appropriate.

By December 1981, Company X had hired a person with HSA experience to act as an in-house consultant in health cost containment. By January 1982, the consultant had conferred with project staff and prepared a list of recommendations designed to get the coalition "on track" and moving. By July 1982, the Company X consultant and project staff met with the Beaumont coalition to address several specific issues: a) incorporation of the coalition and formulation of by-laws and dues; b) discussion of specific means of establishing utilization review in Beaumont (and organizations that could be hired to perform UR services); and c) establishing discussions with area hospitals and physicians to address the problems and solutions for Beaumont. The meeting was very productive and follow-up discussions and action appear imminent.

2. Internal Cost Containment

Project staff continued to encourage Company X to reconsider their HMO stance -- to recognize that failure to support or develop HMO activity at their sites was not only "neutral", but in reality a negative influence on competition and internal cost control. This encouragement took the form of informed conversations, written material, and presentations by project staff. Company X's consultant, referred to above, has voiced a much more positive HMO stance and his recent presence likely indicates a willingness to rethink HMOs as a means of cost containment.

Prior to our contact with Company X, Benefit Plan Administration had taken significant initiatives in the area of benefit design. They had incorporated six cost containment features (preadmission testing, second surgical opinion, ambulatory surgery, home health care, extended care, and programs in alcoholism/chemical dependency). They also had developed a cash rebate policy to reward employees on the basis of lower cost claims experience (contribution bonus). Project staff encouraged their efforts and made further recommendations of benefit design that would provide proper incentives for employees.

In July 1982, project staff spent three days at New York headquarters interviewing representatives from each of the divisions under employee relations. The purpose of the interviews was to critically assess Company X's health cost management strategy. Appendix F is the final report from this series of interviews. Areas of recommendation include: a) encouraging a corporate policy statement on cost containment; b) centralizing containment responsibility; c) focusing data collection and analysis, coalition activity, and ADS involvement on the three control objectives -- availability of services, use of services, and price of services.

Company X has taken two significant steps toward cost control. In Fairfax, VA they have proposed to establish private utilization review through the local Foundation for Medical Care. Company X has also negotiated with a new claims administrator for the company's California sites. This administrator monitors utilization data and takes action on the employer's behalf to alter provider's behavior to control costs.

3. Retiree Demonstration

Company X expressed a great deal of interest in exploring with the project staff the possibility of a Medicare demonstration for retired employees. The project staff prepared material regarding the demonstration's feasibility and all issues potentially of concern for Company X. A meeting between Company X's benefit plan staff and the project team was arranged in October 1981 to work through the proposed demonstration in detail. Four sites were selected by Company X and project staff prepared county-specific data on estimated 1982 Medicare capitation rates and physician distribution data for each site (Beaumont, Dallas-Fort Worth, Southern New Jersey, and New York City).

Despite Company X's interest and the well-considered investigation accomplished by Company X and project staff, Company X decided they could not go ahead with the demonstration. Company X cited three major reasons for withdrawing: 1) the company would face a potentially high financial risk; 2) the commitment of staff time would detract from other cost containment efforts; 3) their HMO policy and HMO enrollment history would be a disadvantage in such a demonstration.

4. HMO Sponsorship

In the "HMOs as a new venture" exploration, the project team was unable to get past the benefits department. We attribute this, in part, to X's reluctance to appear to favor HMOs and to the strong role corporate medical plays within the personnel division. The director of benefits expressed no interest in carrying the HMO sponsorship exploration further, either within his department or with new ventures executives.

There was, however, considerable interest expressed in Preferred Provider Organizations (PPOs). Company X was particularly interested in the possibility of directing employees to a PPO (as in Denver) or establishing a new PPO for employees (as in Beaumont, through coalition activities). Project staff initiated conversations between headquarters staff and our contacts with the Denver PPO (Mountain Medical Affiliated).

Analysis:

The analysis of Company X must focus on two major points: 1) the company's emphasis on benefit design as the major means of controlling health care costs and 2) the company's neutral stance on HMOs as a means of cost control. The company has been hesitant to focus its attention beyond internal issues of benefit design in order to take positive action in the medical community. Company X still tends to play a "participant" role on several coalitions (including Beaumont), rather than an "activist" role. There continues to be a tendency for Company X to focus on the employee's use of health resources in deference to the use of resources by physicians -- an approach encouraged by Company X's Corporate Medical Department. In the same vein, there is significant interference by corporate medical in the area of establishing private utilization review. An overall problem in Company X is the lack of a broad, coordinated strategy to meet the health cost problem. Their efforts are decentralized and poorly communicated among departments.

However, as mentioned above and summarized below, there are several very encouraging signs -- indicators that Company X is becoming more comfortable with the concept of becoming a "product buyer" of health care and calling for some constructive change in the medical community.

Critical Factors:

Positive:
1) A new consultant for cost containment in the benefits department.
2) A new claims administrator concerned with cost containment and utilization control.
3) A proposed private utilization review contract in Fairfax, VA.
4) An interest in Preferred Provider Organizations.

Negative:
1) The persistence of a neutral HMO stance.
2) A pattern of inaction on coalitions.
3) A decentralized and ill-defined strategy for implementing a cost management program.
4) A conservative Corporate Medical Department.

D. Conclusions for Phase 2 (Years III & IV)

Over the course of these two years, the project team worked with five very large corporations. This section describes the project from three perspectives:

Were the specific objectives of the project met?

Are there tangible outcomes -- company actions -- which indicate progress toward the overall goal?

What factors appear to have influenced the outcome?

- *Were the specific objectives of the project met?*

There were three specific objectives which guided the project team in its work with the target companies. The objectives were stated as activities to be conducted jointly by the project team and each individual company, and allowed for considerable variability in designing a workplan. The project team feels that the three objectives were met, as the following summary indicates:

Objective 1: Work with each company to select a target community. Completed in Year III.

Objective 2: Work with each company to take action in the target community which is supportive of ADS growth and development; assist the companies in internal cost containment activities. The project team did establish a workplan and conduct activities in at least one target community for each company. We were, however, disappointed in the general level of accomplishment in those communities. (Our assessment is in the final portion of this section.)

We also conducted a variety of activities related to internal cost containment or policy positions regarding ADSs. As the company summaries indicate, they ranged from a joint exploration of how companies can monitor health care costs and utilization (data monitoring seminar), to improvements in HMO offering procedures and materials, an evaluation of a company's overall cost management approach, advice on HMO selection, an HMO contribution methodology, and an

analysis of a company's health care cost experience. In fact, the companies were more receptive to the internal activities than to the work in communities. This may be the result of working with very large, highly centralized companies for the most part, whose headquarters' staffs tend to concentrate on internal corporate issues and activities.

Objective 3: Explore two areas with each company -- the feasibility of a retiree demonstration project and direct sponsorship of ADSs. The project team felt that we engaged each company in an adequate exploration of the two issues; that is, each company participated in discussions with the project team and had an opportunity to use the project team for extensive in-depth investigation. Three of the companies pursued the retiree issue in depth; two companies brought its new ventures staffs into a detailed discussion of ADS sponsorship possibilities.

- *Are there tangible outcomes -- company actions -- which indicate progress toward the overall goal?*

Tangible outcomes are considered by the project team to include actions by a company which promote the growth and expansion of existing ADSs or the development of new ADSs; actions by a company to establish a retiree demonstration project; or corporate exploration, beyond the project termination, of one of the major project goals. The following section assesses tangible outcomes, directly attributable to this project, within each of the four major content areas: action in communities, internal cost containment, retiree demonstration, and ADS sponsorship.

1. Action in communities. The following provides an overview of project activities and outcomes for each company's target city. They are listed in general order of accomplishment. Project staff considers the Dayton effort to be the most successful of the five, since the entire focus of the employer coalition was to strengthen the two HMOs and promote competition in health care delivery as a long-range strategy for the community.

Company	City	Community Outcomes
K	Dayton, Ohio	Active participation by local Company K representatives in a coalition strongly supportive of two newly developing HMOs; conducted an HMO evaluation and urged other employers to make positive HMO offerings.
M	Philadelphia, Pennsylvania	Independent action by local Company M representatives to plan a PPO for Company M employees. Planning efforts continue at this date.
O	Gary, Indiana	Independent action by headquarters and local staff to improve HMO offering materials and procedures. Efforts to form a coalition failed.
X	Beaumont, Texas	Company X initiated an employer coalition from headquarters level. Little progress in developing an action plan after a one-year effort.
P	Binghamton, New York	Coalition initiated by another company just prior to project start. Project team failed to direct coalition efforts toward ADS formation.

2. Internal cost containment and ADS policies and procedures. A variety of activities were pursued under this general area which tailored to the needs and interests of the individual companies. In general, the project staff believes that all five companies developed a more positive attitude toward HMOs and other ADSs during the course of the project, but it is difficult to measure the effect of the general "climate building" that occurred. The section below summarizes only the specific activities and tangible outcomes within each company.

Company	Internal Policy & Program Outcomes
K	Project staff assisted the company in assessing new HMOs under consideration; K did expand the number of HMOs offered, although factors other than this project undoubtedly contributed. An HMO evaluation protocol developed by project staff for Dayton is under consideration for general use by the company. Staff failed to persuade the company to give rebates to employees choosing HMOs whose premiums were below insurance premiums.

Company	Internal Policy & Program Outcomes
M	Provided a form for company to discuss its monitoring system and special studies with other interested and experienced companies (data seminar).
O	Revised HMO offering materials (letter and benefit comparisons) and procedures for one location -- enrollments increased by 28%. Company will use revised approach elsewhere. Did not persuade company to actively offer several HMO choices with rebates for employees choosing lower cost plans. Assisted company in improving its data monitoring.
P	Evaluated company's data to identify high cost location and suggest appropriate cost containment approaches. Company did further upgrade its monitoring, presumably related to project staff's work and the data seminar.
X	Did not persuade company to adopt a positive HMO stance, but in the course of our work they hired a cost containment specialist who intends to pursue that goal. Evaluated company's cost management program; staff's recommendations for a coordinated, comprehensive approach are under consideration.

3. Retiree demonstrations. Two of the companies, P and M, decided after our initial discussions not to pursue the possibility of a retiree capitation demonstration. Three others continued exploration with the project staff. The figure below illustrates outcomes with the three. In spite of considerable interest expressed by all five companies, only Company K continues to pursue this option.

Company	Retiree Demonstration Outcomes
K	Company K pursued both an HMO option and an insurance option. Initiated a joint meeting with two HMOs, three insurers, HCFA staff, and the project team. Tentative plans to offer one HMO next spring to retirees in Michigan; discussions continue with at least one insurer.
O	Entered discussions with a university medical school interested in establishing an HMO and enrolling Company O retirees. Outcome unknown, company taking a reactive position only.
X	After considerable analysis to determine the feasibility of an insurance approach, decided the financial risk was too great and required staff time too high.

4. ADS as a new venture. None of the five companies decided to pursue formal feasibility studies. Two of the companies were interested enough to consider it at the highest appropriate level in the corporation: top executives in the new ventures or strategic planning divisions. Both decided that it was not attractive enough and closed the discussions.

- *What factors appear to have influenced the outcomes?*

Because the nature of the project activities varied substantially, this section is divided into three sections: action in communities, retiree demonstrations, and HMOs as a corporate venture.

1. Factors: Action supportive of ADS growth and development in communities. Four of the five companies were generally favorable toward HMOs at the beginning of the two-year project. That is, they offer numerous HMOs (regardless of federal qualification), using their own internal evaluation process. Two of them use a particularly sophisticated process for informing employees of the HMO option. All, however, stop short of making an equal dollar contribution to all health plans. None of the companies has become a direct sponsor of an HMO, although local corporate executives do sit on HMO boards and have provided encouragement to health providers who are willing to develop an HMO plan. All of the companies have representatives on several of the 70 or so local health care coalitions, but only a handful of the coalitions have ADSs or a long-range competition strategy as their major focus. The following summarizes the project team's observations on the factors that have inhibitied more direct involvement in ADS formation.

   The five target companies are not unlike their counterparts in American business. Only a handful of U.S. corporations have become direct sponsors of HMOs (e.g. R. J. Reynolds, Deere and Company, Ford Motor Company), and in each case those companies did so only in their headquarters location or to serve a major portion of their work force. No companies that we are aware of contribute an equal $ to all health plans, particularly once HMO premiums become less expensive than the indemnity plan. The five target

companies are fairly representative of other U.S. corporations. Additionally, they are extremely large companies (100,000 to nearly one million employees) and changes of the magnitude implied by the overall project goal may be unrealistic to expect of them in the short term. The inhibiting factors described below are, therefore, common to most American corporations.

Factors Inhibiting Large Corporations in Community Change

a. Corporations are reluctant to institute aggressive cost containment because health benefits are viewed as a mechanism for attracting and retaining employees. Health benefits are the purview of the vice president of personnel or human resources whose charge is to bring in valuable employees and keep them satisfied. Significantly, the vice president of finance is not responsible for purchasing health benefits.

b. Unions have made health benefits a number one priority and have inhibited corporated actions which appear to limit choice, benefit levels, or the use of services by employees. Non-unionized companies maintain attractive benefits, in part, because it reduces the attractiveness of unionization.

c. Corporations are reluctant to take actions that would alienate the medical community. Such action could result in bad publicity or even a boycott of the company's products.

d. Major change in corporate policy or action steps requires the approval of a top-level executive, usually the CEO or, in field locations, the plant manager or director of personnel. Health care benefits have traditionally been a side issue for these executives.

e. Corporations have tended to place health benefits specialists on community coalitions. Unless the benefits staff is supported by top level executives, they are inhibited from taking significant action within the community. The membership composition explains why many

coalitions conduct "safe" activities -- data collection, health promotion, oversight of health planning, etc.

Factors Favoring Corporate Involvement in Health Systems Change

a. A recent return to 20-30% increases in premium costs is likely to elevate concern with companies -- reaching even the CEO if cost increases are not curbed.

b. Steady growth in corporate awareness and involvement in health issues since the mid-1970s is beginning to neutralize corporate reluctance to get involved. One indication that companies are getting serious about "doing something" is the recent trend toward assigning cost containment responsibilities to one individual within the benefits department.

c. Examples of "lead corporations" willing to experiment (e.g., private utilization reviews, closed panel PPOs, HMO sponsorship) will encourage some other companies to develop innovative programs.

2. Factors: Corporate action to initiate retiree health care demonstrations.

A number of factors were cited by the companies as reasons not to participate or to continue with the development of a retiree demonstration project. All three companies were fearful of the financial liability which might be involved, and investigated various ways to reduce this risk. Both Company P and Company O felt HMOs would be a logical approach; however, there were no HMOs where these companies had substantial retiree populations. Further, even while pursuing the HMO approach, Company O was unconvinced of the long term cost effectiveness of HMOs. Company K considered both an HMO and an insured approach. While the insurers are still in discussions with Company K, the insurers are very uneasy about bearing the total financial risk for a retiree population.

The companies had difficulty in allocating staff time to follow up on this project. This problem was one of the reasons given by Company X when it withdrew. This was also a problem with Company O, which continued to

state their interest in the project but never managed to complete the necessary tasks. For Company K, project staff handled several of the initial tasks, relieving company staff from this time constraint. However, whether Company K continues its work on retiree experiments will depend on the willingness of HMOs or insurers to take the lead, as staff time is at a premium in this company as well.

The final common negative factor was some frustration with current actions by the federal government and HCFA to reduce Medicare's liability. The cost shifting issue was a "thorn in the side" of two of the three companies. They thought this project might be another way to relieve HCFA of more of the costs and put the problem on the shoulders of the private sector.

The positive factors (cost saving potential, offering an option to retirees) are likely to outweigh the negatives for Company K. There are attractive HMOs in several locations where K has a concentration of retirees and the company plans to offer the HMO option through an ongoing demonstration by next April.

3. Corporate sponsorship of ADS as a new venture possibility. The project team's contacts with these five companies and its considerable contacts with other major corporations over the last five years leads us to conclude that at this time it is highly unlikely that large corporations not already involved in the insurance or health care delivery industry will find ADS development an attractive investment. The evidence thus far indicates that (1) only insurers or health care-related companies have become national HMO firms (sponsoring HMOs in two or more non-contiguous states) and (2) when asked to give careful consideration to the possibility of sponsorship, large industrial, service, or retailing corporations have decided that investing in HMOs is not feasible or attractive. From our experience, we conclude the following:

> Major corporations, even if they have sufficient capital resources, are not willing to enter directly into health care delivery as a venture proposition. It would be a radically new line of business, so the risk factors appear high. They see little prospect of transferring their capabilities to what is essentially a very unique type of service industry. The paucity of information on return on investment potential of HMOs exacerbates the problem.

APPENDICES

Publications Resulting from
HCFA Grant #18-P-97019/5

The publications listed below are available to interested parties. They may be obtained from the Resource Specialist, InterStudy, P. O. Box S, Excelsior, MN. 55331.

Design for a Corporate Health Care Monitoring System

Design for a Community Health Care Study Process

Discussion of the Corporate Process to Support Alternative Delivery Systems

Developing a Community Health Care Monitoring System (supported in part by the Pew Memorial Trust)

Evaluating Health Maintenance Organizations: A Guide for Business, Labor, and Coalitions (supported in part by the Dayton HMO Task Force, the John A. Hartford Foundation, The Joyce Foundation, and the Henry J. Kaiser Family Foundation)

An Introduction to Preferred Provider Plans (PPOs) (supported in part by the Henry J. Kaiser Family Foundation)

MEDICARE AND BUSINESS

THE PROPOSITION: To investigate a direct payment arrangement (per capita payment) between Medicare and individual businesses. Medicare would transfer to the corporations or to health plans contracting with corporations the authority to provide A and B benefits for their Medicare-eligible employees in a local area.

BACKGROUND

Businesses currently have several options once employees become Medicare eligible:

1. Transfer employees to Medicare with no further corporate involvement.
2. Transfer employees to Medicare and provide help with claims forms, supplemental insurance election, etc.
3. Transfer employees to Medicare and purchase or self-insure supplemental benefits. This may or may not require employee contributions for the supplemental coverage.

Most businesses opt for choice #3; often this includes the business also paying the Part B premium. These benefit programs, which may supplement or complement* Medicare A and B benefits, essentially "carve out" Medicare covered services before determining the program's liability for a claim. Under coordination of benefits (COB) provisions of the insurance industry, Medicare always pays first, before the supplemental plan determines its liability. Insurance companies usually have entire departments to handle COB, but for the self-insured business, COB can be a significant problem.

Because of Medicare, the cost of health insurance for Medicare-eligible employees and retirees may be relatively low, depending on the extent of complementary benefit coverage. For example, a Medicare supplemental contract (which pays Medicare's deductibles and copayments) probably costs between $15 and $24 per month. If the employer also assumed the $11 Part B monthly premium, total premiums for the Medicare eligible would not exceed $35 per month, which

* For purposes of this analysis a Medicare supplemental program is one that fills in the deductibles and coinsurance currently required by A and B, but provides no additional benefits; a complementary program, in addition to filling in deductibles/coinsurance, offers benefits over and above Medicare A and B, such as drug or dental coverage, to subscribers. For simplicity, both types will be referred to here as "supplemental".

approximates the cost of a single contract for a non-Medicare employee or retiree. Dependent coverage, if provided, would increase the company's stake. Since Medicare-eligibles usually constitute a small percentage of a large employer's insured population, the effect on the employer's total health benefits cost may appear small. However, because the elderly use hospital services at approximately three times the rate of the under 65 population, the potential for cost savings on a combined Medicare/supplemental program is even greater than for a younger population with similar benefits. A 30% reduction in hospital days for the elderly allows for substantial savings which can be put back into increased benefits and significantly reduced premiums. It is against this background that we must consider possible arrangements and incentives governing direct contracts between Medicare and individual businesses for their Medicare eligible employees and retirees.

WHY CHANGE?

Why should business assume responsibility and risk for A and B benefits? Possible reasons include immediate cost savings, better service and benefits for retirees, and possible long term payoffs in an extension of a successful experimental design.

Cost savings may occur via:

--Business purchasing A and B equivalent benefits from a private insurer at lower cost.

--Business moving Medicare eligibles into more cost effective systems (HMOs or other organized systems of care).

--Business directly influencing utilization through lifestyle changes, health promotion, and other educational programs.

--Administrative savings.

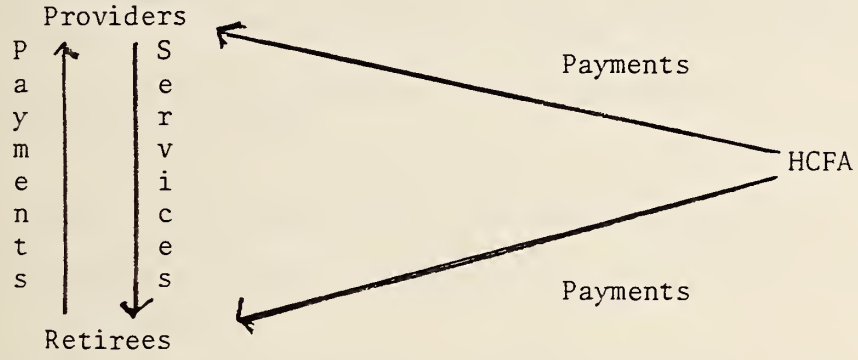
Better services may be provided retirees by:

--Reduced premiums or increased benefits from cost savings.

--Decreased paperwork and claims filing.

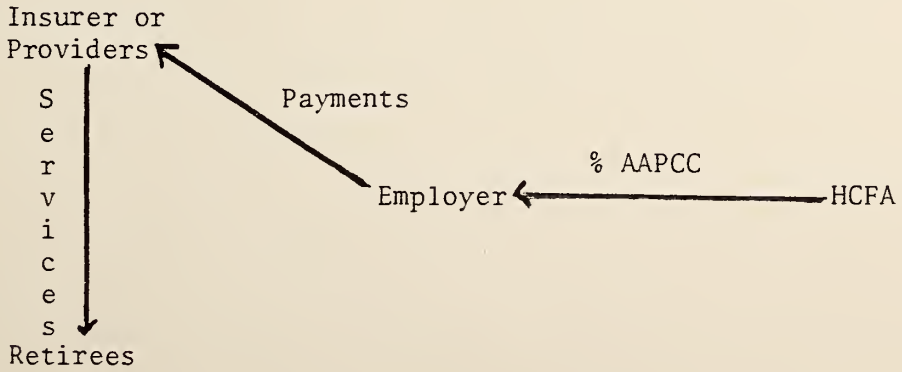
POSSIBLE APPROACHES

Under the current system, once a retiree has received health care, he may either pay directly and be reimbursed by the Health Care Financing Administration (HCFA) or file a claim and have HCFA pay it directly.



HCFA determines the Average Annual Per Capita Cost (AAPCC) for each county in the U.S. based on all paid claims for A & B for the residents of the county. This AAPCC is the base from which any capitation payments would probably be determined.

An alternative method, stated in simplistic terms, would involve HCFA paying, perhaps 95% of the AAPCC to a business which would then be responsible for arranging for an A and B equivalent benefit package or transferring the financial risk to an insurer or health provider organization.



The actual payments to the employer as well as the methods of providing benefits would be subject to negotiation between HCFA and the employer.

There are obviously many issues not considered in the simplistic description above. Some major points are as follows:

--Success depends on the ability of business to arrange for A and B benefits at lower cost or with administrative savings.

--The actual HCFA payment to business would need to be determined, probably based on the AAPCC.

--The HCFA payment to business may need adjustments from the AAPCC to reflect health care need of the business population.

--Favorable or adverse selection may result if employees are given several options.

--Administrative requirements from HCFA probably would include updating of master eligibility records, claims processing procedures, enrollment card alteration, audit needs, utilization and cost data.

--Determinations of eligibility and coverage must meet Medicare guidelines.

--Grievance procedures must follow Medicare regulations.

--Coordination with local intermediaries must be achieved.

--HCFA evaluation requirements may be onerous and need to be explored.

InterStudy
October, 1981

Medicare and Business Demonstration
An Outline of Options

Purpose: To design a demonstration whereby a corporation would accept the responsibility for purchasing Medicare benefits for its retiree population in one or more locations.

Objectives for Business

Any or all of the following could be considered corporate objectives in this project. Each company's experience with its current retiree program will influence the determination of that company's objectives. This program could:

- Save money for the company.
- Add benefits and/or reduce costs to retirees.
- Eliminate or reduce claims processing for--
  company
  retirees
- Provide an integrated program of benefits and eliminate current confusion.
- Make health education and promotion programs for retirees easier for the company to introduce.
- Address the problem of some physicians' reluctance to accept Medicare patients.

Options

In this initial phase, the options are theoretically open-ended. The choices discussed below reflect InterStudy's thinking on options that are likely to be considered by HCFA and are attractive to business. Each company will need to develop a proposed approach that fits its circumstances. Periodic discussions with HCFA will be important in formulating a mutally acceptable demonstration project. (A discussion of some of the issues inherent in these options is presented in a companion paper, "Medicare and Business: Options and Issues").

I. Benefit Package Options

- Level of benefits. The covered benefits will be determined by the company. Current Medicare Part A and Part B benefits will probably have to be included.
- Choice of options. Retirees could choose between high and low options packages or uniform benefits could be established for all retirees.
- Out of area care. If the demonstration is limited to specific providers (HMO, PPO, panel of doctors) special arrangements will be necessary for out of area care.

II. Eligibility Options

- Mandatory participation. All Medicare eligible company retirees in the chosen location are capitated by HCFA.
- Voluntary participation. Retirees would be given a choice of plans; those who remain under the current Medicare program would not be capitated.
- Extent of eligibility. Retirees not covered by Medicare, disabled retirees, dependents, and other special groups may require special arrangements.
- Health status considerations. Categories of retirees could be omitted from the demonstration; e.g. institutionalized or end stage renal disease.
- Term of eligibility. Retirees should probably be required to stay in the demonstration for at least a year.

III. Capitation Rate Options

- A percentage of the Average Area Per Capita Cost (AAPCC). The AAPCC is basically HCFA's cost of providing Medicare benefits in a given county.
- Adjusted Community Rate (ACR). The ACR is the expected cost of Medicare benefits, based on adjustments to current HMO community rates or insurance data in a given area.

IV. Risk Arrangement Options

- Business accepts risk. All costs of Medicare benefits provided under the demonstration will be paid for by the company.
- Business transfers risk. An HMO or insurer may be willing to provide the stated benefits for a given premium.
- A voucher may be given to each retiree to purchase his own benefits as he wishes; those choosing an open ended plan would accept a portion of the risk.
- Risk is spread. Business might agree to an upper level of costs, (110% of capitation rate) providers, insurers, or an HMO might agree to provide hospitalization, office visits, or other services in full; stop-loss insurance might be purchased. Additionally, HCFA may be willing to share part of the risk with business.

V. Provision of Benefits Options

- HMO. Retirees may be required to receive their care through an HMO.
- Panel of doctors. Retirees could be encouraged to see only certain doctors who practice in a cost-effective manner, via increased benefits, decreased out-of-pocket costs.
- Free choice of provider. While this is the current situation under Medicare, it is very difficult to control quality, utilization, or costs. If this approach is used, a utilization review and/or educational effort is recommended.

VI. Marketing Options

- Business markets directly to retirees.
- HMO, insurer, other entity handles marketing.

VII. Lock-in Provisions

- Patients may be limited to specific providers under HMO or alternative coverage.
- Dependent on length of option period, retiree may be able to change option selection to avoid lock-in provisions.

Administration

Since this is a demonstration project, HCFA will probably require some special information to evaluate it. Procedures will also need to be developed to handle routine administrative matters such as eligibility, benefit coverage, premium collection, updating of files, etc.

The role of both business and HCFA would be negotiable; the specifics would be determined during the planning phase of the demonstration.

InterStudy
October, 1981

MEDICARE AND BUSINESS
OPTIONS AND ISSUES

This paper is intended to provide an overview of the issues a corporation will need to address as it examines the feasibility of a retiree demonstration project. It is a supplement to the "Medicare and Business Demonstration: An Outline of Options." The issues in this paper are described for each option category outlined in that summary.

The basic concept of a company arranging for Medicare benefits to be delivered to its retirees is straightforward. However, once a business starts exploring the specific decisions to be made and tasks to be performed, the number of options to be considered grows rapidly. We hope that this paper is useful for identifying decision areas and the issues related to each.

It must be remembered that each of these areas ultimately remains to be negotiated between the corporations and the Health Care Financing Administration (HCFA). InterStudy's role will be that of facilitator in the process, providing assistance and advice to both parties. The assumptions in this paper regarding the options open to business are based upon current Medicare demonstration projects and our projections of what HCFA is likely to consider.

If you have any questions or would like further explanation, please call Jerry Meier or Ann Perkins (612) 474-1176.

I. BENEFIT PACKAGE(S)

The benefits provided should meet several major criteria:

- Medicare Part A and B benefits will probably have to be provided in full.

- The benefits should bear a reasonable relationship to money available to provide them.

- The benefits must be attractive to retirees.

Many companies provide benefits in addition to those covered by Medicare Parts A and B; it may be politically infeasible to limit these benefits in any way. For companies which do not currently supplement Medicare, they may wish to consider covering copayments and deductibles or even adding supplemental benefits. If cost and utilization of services can be controlled, it may be possible to provide some extra benefits without increasing the costs either the company or the retiree must pay. A final option might be to provide benefits equal to those enjoyed by active employees if the company is not already doing so.

Whatever approach is taken, a decision must be made regarding who will pay for supplemental benefits--the company or the retirees. If the retiree has to pay a relatively large premium for the new program, antiselection may result (i.e. only those expecting to use the services often will sign up).

Another option might involve offering the employee a choice, such as between high and low option plans. Again the benefit structure and premium rates must be carefully designed to avoid antiselection.

A very important part of the benefit design is how out-of-area coverage will be handled. Currently, the retiree simply presents his Medicare card anywhere and is insured. If however, an HMO or panel of doctors is used to provide benefits to retirees in a given area, out of area coverage becomes an issue. An HMO enrollee is usually only covered for emergency services outside the HMO service area.

II. ELIGIBILITY

Should the retiree have a choice of the current program or the demonstration? Or, will the company in essence say "If you want coverage, join the demo"? Or, will the company issue vouchers to all eligibles and allow them a choice?

Does the company wish this demonstration to cover all retirees? Only those eligible for Parts A and B? Only those participating in A and/or B? What about disabled retirees? Spouses not yet Medicare eligible? Institutionalized retirees? Are any retirees eligible for Medicaid? What about retirees who spend a significant amount of time out of the area?

All of the above questions can greatly affect the administrative simplicity or complexity of this program. HCFA will only capitate those who are on Medicare. Does the company wish to include other groups and absorb the cost?

Certain extremely high cost cases such as black lung, etc. need special consideration. There is no way a typical capitation rate can cover these expenses. There is currently a special capitation rate for end stage renal disease. Negotiations with HCFA will be necessary to determine a method to handle these and other high cost cases.

Will the retiree have the chance to opt out? How often? And, how often can he/she opt back in? In current demonstrations, the retiree can opt out of an HMO with thirty days notice; however, enrollment in an HMO may take place only during the open enrollment period. Again, reasonable standards in this area will ease administrative costs considerably and also reduce the chance of a retiree joining a given plan when a specific benefit is needed and then opting out afterwards.

III. CAPITATION RATE

One of the main incentives for business to take on a project such as this is the possibility of monetary gain which may either reduce the cost of the program for the company or increase benefits for the retiree. This gain, of course, is contingent on the amount HCFA will pay for each beneficiary to cover A and B benefits. A method which has been used in some HMO demonstrations is for HCFA to determine the Average Area Per Capita Cost (AAPCC) in a given area. Then 95% of the actuarially adjusted AAPCC is paid to the HMO, theoretically giving HCFA a 5% savings. The AAPCC is based on age, sex, aged or disabled status, and institutional status; it does not reflect individual health status. Thus, if only some retirees were covered under a capitation program, the question of health status of those members might arise; i.e. are only the healthy ones enrolled leading to excess profits for the company and no savings for HCFA, or vice versa.

Another method would be to start with the average cost of providing benefits in an area (based on HMO or insurance data) and then adjust this figure for differences in benefits and expected utilization for the retired population. This revised figure currently being used in some HMO Medicare demonstrations is known as the Adjusted Community Rate (ACR). This rate is independent of the AAPCC. If the ACR is less than the agreed upon percentage of the AAPCC, HCFA may only pay the ACR as a capitation rate or may allow the company to provide additional benefits with the difference.

HCFA may want to capitate all the company Medicare eligible retireees in a given area. The company can consider mandatory participation in a controlled system, such as an HMO or other arrangement, for all retirees. If some retirees do not receive their health care from such a system, control of costs and utilization will be very difficult. The company would face the possibility of benefit costs exceeding the defined capitation rate unless it could convince an insurer to provide coverage or would be willing to let retirees absorb cost excesses through the use of a voucher system.

IV. RISK ARRANGEMENT

The amount of money the company receives to provide benefits would be fixed under a capitation arrangement. However, the cost of these benefits would be virtually unlimited, in lieu of some arrangement to control this risk. The company may wish to accept this risk, believing that it can control utilization and costs of services. Or, methods may be explored to pass the risk along or spread it out. For example, coverage for the guaranteed benefits may be purchased from an HMO or insurer, thereby transferring the risk. A hospital or doctor panel might be willing to accept some risk in return for a sweetener such as higher than normal Medicare payments. Or, stop-loss insurance, per claim or total excess cost, might be purchased. Also HCFA might be willing to provide some reinsurance.

It should be noted that very few insurers or HMOs have experience with this sort of arrangement and might be cautious about entering into any agreement of the types set forth above.

Another way to avoid some of the risk would be through a voucher system. Under this system, retirees would have a fixed amount of money to purchase health care as they saw fit. They might choose insurance or an HMO or might choose to pay each bill as it came. Retirees could be at risk for the total cost of their care, or some limit could be placed on the amount each retiree would need to pay out-of-pocket.

V. PROVIDERS

The success of the demonstration is largely dependent on controlling the utilization and costs of services provided. This implies that however the services are provided, strong control mechanisms, whether from the providers, the company or another source, must be in place.

If an HMO is selected, incentives and systems to control use are already in place. Insurers, however, tend more to look at individual claims and deny a portion of high claims rather than creating an incentive system. Further, insurers may be reluctant to take on a project such as this with open-ended risk since the Medicare supplemental policies they are used to offering typically have far lower benefits and possible cost impacts than insuring all Medicare benefits. However, if insurers could offer an actuarially equivalent benefit package different from Medicare, they might be willing to participate.

If a group of doctors is known to practice in a cost-effective manner, a contract might be set up with the group. Patients need not be told which doctor to go to; rather if they saw certain doctors all of the bill might be paid versus 80% if they went to other providers. A similar arrangement could be made with a selected hospital. By locking in a group of retirees to a given hospital, the hospital may have incentives to diversify in ways to serve that population, such as providing skilled nursing beds or home health services.

Several problems dealing with providers need to be explored. Medicare currently pays doctors 80% of an out-of-date fee schedule. Thus, doctors may get only 50-60% of their fee from Medicare. If they are asked to provide Medicare benefits to a defined population, one of their first questions may concern the fee schedule. Since the AAPCC is based on what HCFA actually pays, there may be little room to pay providers higher amounts.

As noted previously, most likely <u>all</u> A and B benefits must be provided. If contracts are made with an HMO or a panel of doctors, special arrangements will be necessary to cover those benefits required but not available in-house. For example, most HMOs do not have chiropractors or podiatrists on staff but would be required to provide those services.

VI. MARKETING

Retirees need to be informed and educated to make rational decisions once the eligibility and benefit questions have been answered. The company may wish to provide this service itself, or contract it out to a selected provider (HMO, insurer, other). Different marketing methods may be required for current retirees and future retirees. Marketing materials can have a substantial impact on the type of group who elects a specific coverage. (Only low utilizers or perhaps only the sickest people might be attracted by specific marketing strategies). Throughout the course of this project, HCFA will want to examine all marketing materials.

VII. LOCK-IN PROVISIONS

If business contracts with an HMO or group of doctors to provide care, there must be some sort of mechanism to ensure that care is given only by those specific providers. Otherwise, the vital element of control will be lost. However, Medicare beneficiaries are used to going wherever they choose, to whatever provider they wish. A substantial educational effort will be necessary for beneficiaries to understand the lock-in provision, its purpose, and how it affects the manner in which they receive care.

Related to this lock-in provision is the question of out-of-area use previously discussed. Also related is the frequency with which a retiree can switch from plan to plan -- if he doesn't like the lock-in he may merely change the benefit option.

VIII. ADMINISTRATION

There are special requirements associated with this demonstration. One area involves responsibility for the basic administration to ensure that proper coverage is provided each retiree, that HCFA has an up-to-date listing of current beneficiaries, and that premiums are being collected. The claims administration and appeal procedures must also be developed. Another area concerns audit and evaluation requirements. Since this is a demonstration project, HCFA will want to evaluate it. This evaluation may include examining various company and subcontractor business and employee records.

The nature and extent of business's and HCFA's obligations under this demonstration would be negotiated in advance.

SUGGESTIONS FOR A
BUSINESS/MEDICARE FEASIBILITY STUDY

1. Select location(s) where project appears likely.

   a. Based on criteria developed by business (costs, number of retirees, benefit levels, availability of alternative delivery systems, etc.) evaluate two or three likely communities.

   b. Identify population eligible to participate in project.

      Decide whether all eligibles in area or selected segments of retiree population. Collect data on age, sex and number of dependents.

2. Formulate major policies governing project (see options and issues paper).

   The company may want to evaluate the feasibility of two different approaches or variations on a single basic approach.

   a. Benefit package

   b. Eligibility options

   c. Capitation rate

   d. Risk arrangements

   e. Provider participation (HMOs, preferred provider, etc.)

   f. Marketing

   g. Lock-in provisions

   h. Administration

3. Perform financial feasibility study (see attached data list)

   a. Project utilization and cost levels of enrolled population based on historical data (HCFA and company).

   b. Project reductions in utilization and costs brought about by utilization and cost control procedures.

   c. Estimate total cost of program and compare to projected capitation from HCFA.

c. Utilization of non-Medicare benefits under supplemental benefit program.

1. Prescription drug use.

2. Dental Services

3. Eye glasses/hearing aids, etc.

4. COSTS

a. Costs of all utilization categories identified in 3.

b. Average out-of-pocket costs of general Medicare population*; of target population.

c. Costs of each benefit category in supplemental benefit program.

* d. Average Area Per Capita Costs for Medicare.

e. Costs to administer supplemental program.

* f. Approximate percent of physicians' charges being paid by Medicare in the community.

* g. Cost trends for Medicare benefits over time.

h. Cost trends for supplemental benefits over time.

i. Physician charges in excess of Medicare's allowable charge.

5. PROVIDERS/INSURERS

a. Costs of Medicare supplemental programs in the community; typical (average) benefit coverage.

b. Medicare utilization experience of HMOs, hospitals, or other specific provider subsets in community (geriatric clinic, nursing homes, Medicaid long term care, etc.).

c. Insurance companies offering supplements in community.

d. Health delivery networks and community-based care programs in the community.

e. Free or discounted service providers in the community.

f. At-risk providers in the community.

* Denotes information available from the federal government

BUSINESS/MEDICARE FINANCIAL FEASIBILITY INFORMATION REQUIREMENTS

NOTE: The following list of data requirements presents an ideal data set. We recognize that not all of this data can be obtained. Also, this information should be gathered after the company has selected the target location for the demonstration. All of this data should be location-specific.

1. ELIGIBLE POPULATION

   a. Identify portion of retirees and active employees who are Medicare beneficiaries (aged or disabled).

   b. Identify retiree or active employee dependents who are Medicare beneficiaries and for whom company pays or sponsors benefits.

   c. Are there sub-categories of Medicare eligibles (aged versus disabled--single contract versus family--purchased versus sponsored)?

   d. Age and sex mix of eligible population.

* e. Age and sex mix of overall Medicare population in the area.

2. BENEFITS AND PREMIUMS

   a. What level of benefits beyond Medicare A and B is company purchasing or sponsoring for eligible population?

   b. Premium contributions by company; contribution by individuals.

3. UTILIZATION RATES

   a. Inpatient Hospital Use (days/1,000)

   * 1. Of overall Medicare population in area

      2. Of company's eligible (or target if less than eligible) population.

   b. Part B (outpatient utilization)

      1. Average office visits per person per year/general Medicare population* and target population.

      2. Hospital outpatient utilization per person per year; general Medicare population* and target population.

* Denotes information available from the federal government

4. Identify other contractual arrangements that may be related to project. (HMO, PSRO, hospitals, etc.).

5. Identify staffing requirements to manage the project.

6. Review federal and state statutes governing employee benefits programs (ERISA, etc.) to ascertain impact on project and possibility of waivers.

7. Assess HCFA reporting and evaluation requirements under the project.

8. Based on review of the above, decide whether to move forward with the project.

HEALTH CARE AND RELATED DATA: BEAUMONT-PT. ARTHUR-ORANGE, TX (SMSA)

DEMOGRAPHIC DATA[1]	BEAUMONT	U.S. TOTALS	ALL SMSAs
1970 population	348,000		
1980 population	375,497		
Net migration (1970-78)	-1.2%	3.3%	.5%
% of population 65+, 1975	9.6%	10.5%	9.0%
Median household income, 1980	$21,793	$19,146	$20,523
% of households $0-7999	18.3%	23.5%	
% of households $8-9999	4.0%	6.0%	
% of households $10-14,999	10.3%	16.3%	
% of households $15-24,999	26.9%	30.7%	
% of households $25,000+	40.5%	23.5%	
Civilian labor force, 1980	163,700		

HOSPITAL DATA[2] (COMMUNITY HOSPITALS)	BEAUMONT	ALL SMSAs	INTERSTUDY ADEQUACY LEVELS*
# of hospitals	10		
# of beds	2009		
Beds/1000 pop.	5.4	4.5	3.0 max.
Hospital employees/1000 pop.	13.4	14.0	9 max.
Admissions/1000 pop.	212	165	130 max.
Inpatient days/1000 pop.	1410	1281	800 max.
Occupancy rate	72.0%	77.9%	85% min.
Length of stay	6.7	7.8	
Surgeries/1000	93.2	91.5	
Expenses/inpatient day	$238.54	$304.66	
Expenses/capita	$336.48	$390.32	

[1] Statistics for States and Metropolitan Areas, 1977 and 1980 Census of Population and Housing, 1981, U.S. Bureau of the Census. Income data are from Sales & Marketing Management, 1980. Labor force data are from U.S. Dept. of Labor's Area Trends, 1980.

[2] Hospital Statistics, 1981 Edition, American Hospital Association, reporting 1980 data. Some figures are derived.

*Based on Walter McClure's estimates for a "well organized health system."

III. Trends in Hospital Utilization: 1976-1980

Year	Population (000's)	Admissions/1000 % Change	Days/1000 % Change
1976	357.0	-4.1%	-4.2%
1977	364.4	5.5%	2.2%
1978	364.3	3.6%	2.1%
1979	368.3	1.7%	1.7%
1980	375.5	5.4%	5.4%
AVG. 1976-80		2.4%	1.4%
SMSA AVG. 1976-80		0.7%	0.3%

COMMENTS:

IV. Trends in Hospital Costs: 1976-1980

Year	Costs/Capita As % of U.S.	Costs/Capita % Change	Assets/1000 % Change
1976	86.8%	12.5%	15.4%
1977	96.0%	26.1%	25.8%
1978	97.3%	13.3%	NA
1979	95.2%	9.9%	NA
1980	99.2%	17.9%	NA
AVG. 1976-80	94.9%	15.9%	20.6%*
SMSA AVG. 1976-80	113.9%	13.4%	12.7%*

COMMENTS:

* These averages are for the two year period 1976-1977.

V. Medicare Indicators of Medical Costs. The indexes are used to standardize Medicare per capita reimbursements so that a county's costs may be compared with all other counties. The ratio of a county's age/sex "adjusted per capita expenditures" to all U.S. "adjusted per capita expenditures" describes the geographic index. An index greater than 1.0 indicates that the county's over 65 residents are receiving disproportionately expensive medical care.

MEDICARE INDICATORS OF MEDICAL COSTS: 1976-1980

County	Geographic Index Hosp. Costs (1980)	Avg. Annual % Chg. 76-80	Geographic Index MD Costs (1980)	Avg. Annual % Chg. 76-80
Hardin	1.190	-0.5%	.969	-6.2%
Jefferson	1.203	1.0%	1.064	-2.4%
Orange	1.250	-2.8%	1.116	-2.3%

COMMENTS:

VI.

PHYSICIAN DATA[3] (NON-FEDERAL)	BEAUMONT	ALL SMSAs	TOTAL U.S.
Active Physicians (MDs)	386	312,687	361,915
Physicians/1000	1.0	1.85	1.60
% General Practice	22.3%	10.5%	13.2%
% Medical Specialties*	20.7%	21.7%	21.0%
% Surgical Specialties*	29.8%	22.4%	22.6%
% Other Specialties	22.3%	18.6%	18.2%
% Hospital Based	4.9%	26.8%	25.0%
% of MDs in Residency	0.3%	17.4%	15.4%

The InterStudy adequacy level for a well organized delivery system is 1.3 physicians per 1,000, of whom 55% are primary physicians.

COMMENTS:

VII. MULTI-SPECIALTY GROUP PRACTICES

None noted.

* "Medical specialties" includes pediatrics and internal medicine. "Surgical specialties" includes obstetrics and gynecology.

[3] Physician Distribution and Medical Licensure in the U.S., 1980, American Medical Association, 1981.

VIII. ALTERNATIVE DELIVERY SYSTEMS

A. OPERATIONAL ALTERNATIVE DELIVERY SYSTEMS

Name of HMO	Oper. Date	Model Type	# MDs	12/81 Enrollment	12/81 Adm/1000	12/81 Days/1000

None noted.

B. PREOPERATIONAL ADSs

Sabine Naches Health Plan - conducting a federally funded feasibility study. The HMO has the support of the Chamber of Commerce and the AFL-CIO and would prefer to locate private funds for development.